TRICARE Standard Handbook

FOR YOUR RECORDS

Health Care Finder's Name_____

_____

Phone _____

Health Benefits Adviser's Name_____

_____

Phone _____

Primary Care Manager's Name_____

_____

Phone _____

Your Military Sponsor's SSN _____

Phone _____

Military Health Care Facility _____

Appointments/phone _____

Emergencies/phone_____

TRICARE Contractor's or Claims Processor's Name

_____

Address _____

Toll-free phone _____

Primary/Supplemental Insurance Company

_____

Policy No._____

Address _____

Phone _____

Emergency Numbers

_____

_____

_____

Ambulance Number _____

Poison Control Number _____

Before You Go Any Further...

- If you're planning to get civilian health care under TRICARE (which includes TRICARE Standard, formerly known as CHAMPUS)—do you need a **Nonavailability Statement**? (See the handbook section on "Where to Get Care" for details.)

- Before you file a TRICARE claim (or have one filed on your behalf by a provider of care)—if you have other health plan coverage (including HMOs or other liability insurance, such as auto, home, etc.) in addition to your TRICARE benefits, you usually must file with that insurance plan before a claim is filed with TRICARE. (See the section on "How to File a Claim" for details.)

  Remember:

  TRICARE doesn't decide who's eligible for uniformed services health care benefits. That's done by each service branch. Eligibility records are kept in the DEERS computer files. DEERS is the Defense Enrollment Eligibility Reporting System. All active and retired military members are listed automatically, but they must take action to have their family members listed or deleted. They must also enter all changes, such as marriages, divorces, adoptions, changes of address, etc., into the DEERS database. (See the end of the "Who's Covered?" chapter for more information about DEERS, including toll-free telephone numbers with which you can call the DEERS office where records are kept, in Monterey, Calif.)

- Many changes have taken place in the military health care system in the past several years. Changes are still hap-

pening. The most important of these changes is the transition (now almost completed) to the Defense Department's TRICARE managed health care system. TRICARE offers a choice of three health care options: TRICARE Prime (a health maintenance organization or "HMO"-type system in which you enroll for a fixed period); TRICARE Extra (a network of providers which you may use on a case-by-case basis at a discounted cost-share); and TRICARE Standard (the new name for CHAMPUS, in which you see the authorized health care provider of your choice, then file a claim—or the provider does it for you—for reimbursement by the regional TRICARE contractor). Read more about TRICARE in the chapter which briefly discusses TRICARE Prime and TRICARE Extra.

- Some changes may have taken place in TRICARE since mid-1997, when this book was completed. The best way to keep up with these changes is to stay in touch with your nearest Health Benefits Adviser (HBA), Health Care Finder (HCF) or TRICARE Service Center (TSC).

It's important to talk to your HBA at the nearest military hospital or clinic, to the people at your TRICARE Service Center, or to your Primary Care Manager (if you're enrolled in TRICARE Prime) ***before*** you try to get care from either a military or civilian source.

How to Use This Handbook

Will you be using TRICARE Standard, TRICARE Prime, or TRICARE Extra? This handbook tells you how.

Check out the table of contents first. It directs you to the right sections for the answers to your questions about various aspects of the three TRICARE options.

If you don't understand the meaning of a particular word or term, check the glossary in the back of the book. Terms and words that have a special meaning under TRICARE are explained there.

If you can't find what you want in the table of contents, check the index, which is in the back of the book.

This handbook deals primarily with care received in the United States. Overseas procedures may differ slightly. When that's true, it will be so indicated. Check with your local overseas Health Benefits Adviser, TRICARE Service Center or Health Care Finder if you have questions.

Remember, this handbook does not cover all of the details and special rules of TRICARE. And, certain rules may change over time. That's why your HBA, HCF and TSC are so important. Their job is to help you use your health benefits through uniformed service hospitals and clinics, and through TRICARE. To get in touch with your nearest HBA, HCF or TSC, call the information number at the local military base or hospital. If you don't know what hospitals or clinics are located near you, check the back of this book for a list of medical facilities by state, region or country.

Some Words of Caution

Just because your civilian or military doctor tells you that you need certain care doesn't mean that TRICARE can help pay for it. If you aren't sure whether TRICARE covers a service or supply, contact your HBA, HCF, TSC or your TRICARE contractor. *They can advise you about covered services, but they can't guarantee payment by TRICARE.* That determination comes later, after a claim has been submitted. If you're enrolled in TRICARE Prime (the HMO-type TRICARE option), be sure to see your Primary Care Manager (PCM) for a referral before getting any type of specialized medical care. After the PCM makes a referral, the HCF issues an authorization for the care. Your PCM usually contacts the HCF for the authorization, but you may wish to ask the HCF for help in locating a provider and making an appointment.

Also, remember that you, not TRICARE, are receiving the care, and you are responsible for making sure that payment is made for the services you receive.

And don't forget—if you have other medical insurance, you or your health care provider must first file a claim with that insurance plan (unless it's a policy that's designated as a TRICARE supplement) and receive a payment determination before filing with TRICARE.

Keep in mind that the applicable federal law and the **CHAMPUS Regulation (DoD 6010.8R)** are the final word on any issue. If there is any difference between this handbook, what anybody tells you, and the law and regulation, it's the law and regulation that count legally.

You Can Make a Difference

Fraud and abuse drive up health care costs. Review your bills and Explanation of Benefits (EOB) forms carefully for any discrepancies (for example, there are charges on the bill for services you didn't receive, or the person identified on the bill as providing the care isn't the one you got the care from). Notify your TRICARE contractor immediately. You can make a difference in fighting health care fraud and abuse. (See the end of the "Tips on Using TRICARE Standard" chapter for more information.)

TRICARE Information On-Line

You can find this handbook—as well as other information about TRICARE—on the Department of Defense (DOD) World Wide Web home page.

The address is **www.ha.osd.mil**. Click on "TRICARE Support Office (TSO)" or go directly to the TSO home page at **www.tso.osd.mil**.

We welcome any suggestions you may have to improve this handbook. Please send your suggestions to TRICARE Support Office (formerly known as OCHAMPUS or as CHAMPUS headquarters), Public Affairs Branch, Aurora, CO 80045-6900.

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A Look at TRICARE

TRICARE: What Is It?

TRICARE is the name of the Defense Department's new regional managed health care program for service families. Under TRICARE, you'll generally have three choices of ways in which to get your health care:

- TRICARE Prime
- TRICARE Extra
- TRICARE Standard (formerly called CHAMPUS)

Here's a brief look at each of the three options:

TRICARE Prime

This is a voluntary health maintenance organization-type (HMO) option. If you decide to get your health care through TRICARE Prime, you'll pay an annual enrollment fee (except for active-duty families, who may enroll free) and enroll for a year at a time. Normally, you'll receive your care from within the Prime network of civilian and military providers.

You'll either choose or be assigned a Primary Care Manager (PCM) from within the contractor's network or at your nearest uniformed services medical facility, who will furnish most of your care and will manage all aspects of your care,

including referrals to specialists. The Health Care Finder (HCF) assists in finding the appropriate specialty care for you.

Covered services will be like those of regular CHAMPUS (now known as TRICARE Standard), plus additional preventive and primary care services that aren't covered under TRICARE Standard or TRICARE Extra. For example, periodic health promotion/disease prevention surveillance screenings (most people think of them as routine physical exams) are covered at no charge under TRICARE Prime. Prime also covers certain immunizations, as well as examinations for various cancers and infectious and cardiovascular diseases, and other screenings, with certain age and frequency limitations.

Is TRICARE Prime the Right Plan For You?

It depends. On the one hand, TRICARE Prime is the least costly of the three TRICARE options. You'll be able to predict your health care costs more exactly. As noted earlier, there's no enrollment fee for active-duty families—just modest co-payments when you get health care within the Prime network of civilian providers.

Prime is easy to use. You'll have a Primary Care Manager (PCM) in the Prime provider network, from whom you'll get most of your care, and who will refer you to specialists within the network when necessary. Your local Health Care Finder (HCF) at the TRICARE Service Center (TSC) will make the arrangements for you to get the specialized care after you receive a referral from your PCM.

The services of Health Care Finders are available to you 24 hours a day, seven days a week. And the various TRICARE Service Centers in the region served by your contractor will

have representatives available during regular business hours to provide a variety of information about all aspects of your health benefits.

There's less paperwork with Prime. When you get care from a provider who's part of the Prime network, you don't have to file claims (but if you should seek care from a non-network provider, you or the provider may have to file a claim with the regional TRICARE contractor).

On the other hand, TRICARE Prime may not be your best bet if you have other health insurance that's your primary coverage. In such a case, Prime will only pay ***after*** your other insurance has paid whatever it's going to pay for your civilian care. Also, ***if you discontinue your other health insurance when you enroll in Prime, and later become ineligible for Prime, you might have difficulty getting your other insurance back.***

Or, if you travel out of your TRICARE Prime service area very often, Prime might not be your best choice. The reason: When you get civilian care outside your TRICARE Prime service area, Prime will only pay for emergency services—unless the care you receive has been authorized in advance by the Health Care Finder in your home service area.

You might not want to enroll in TRICARE Prime if you don't want to be restricted to using only providers who are members of the Prime network. A better choice might be either the TRICARE Extra or TRICARE Standard (CHAMPUS) options, which are described later in this chapter.

When you enroll in TRICARE Prime, your enrollment is for one year at a time. During the enrollment period, you're "locked in" to using only Prime (with the expensive exception

of getting care under the “point-of-service” option—more about that later in this chapter) unless you become ineligible for TRICARE during the enrollment period, or unless you move from your local TRICARE Prime service area to a non-Prime area and have to disenroll from Prime as a result.

Note:

There are no pre-existing condition limitations for enrollment in TRICARE Prime—or for use of the other two TRICARE health care options, Extra and Standard.

TRICARE Extra

In this option, you don’t have to enroll or pay an annual fee. You do have to satisfy an annual deductible for outpatient care, just as you do under TRICARE Standard. (See the section on TRICARE Standard below, and also see the chapter titled “How Much Will It Cost?” for more information about the deductible under TRICARE Standard.) The deductible and cost-sharing works the same way under TRICARE Extra.

On a visit-by-visit basis, you can seek care from a provider who’s part of the TRICARE Extra network, get a discount on services, and have reduced cost-shares—five percent less than under TRICARE Standard. Also, you generally won’t have to file any claim forms. You pay annual deductibles for outpatient care before government cost-sharing starts, as you do under TRICARE Standard. You can get a list of the TRICARE Extra providers by contacting one of the TRICARE service centers located in your region, or by calling the toll-free number established by the TRICARE contractor.

TRICARE Standard

This option is the regular CHAMPUS program with a new name. It pays a share of the cost of covered health care services that you obtain from an authorized non-network civilian health care provider. There's no enrollment in TRICARE Standard. You'll. You'll pay the normal TRICARE Standard deductibles for outpatient care, and your cost-sharing percentages will be the same as for regular CHAMPUS.

When Will TRICARE Come to Your Area?

Early versions of the TRICARE managed health care program have been operating in a few places around the U.S. for several years. The current TRICARE program is being placed into operation, region-by-region, nationwide. It should be fully in place by mid-1998. Here's the schedule for implementation, beginning with the first Department of Defense Health Service Region to begin the program:

Region 11 (Washington, Oregon, plus the following six counties in northern Idaho: Benewah, Bonner, Boundary, Kootenai, Latah and Shoshone). Began March 1, 1995. Contractor: Foundation Health Federal Services. Toll-free phone: 1-800-404-0110.

Regions 9, 10 and 12 (California, Hawaii, and the Yuma, Ariz. area). ***Except*** for Yuma (Yuma's inclusion in Region 9 began April 1, 1997), TRICARE operations began Oct. 1, 1995 (had an early form of TRICARE for several years before that). Contractor: Foundation Health Federal Services. Toll-free phone: 1-800-242-6788.

Region 6 (Oklahoma, Arkansas—***except*** for a small piece of northeastern Arkansas that's in the Naval Hospital, Millington, Tenn. service area—most of Texas ***except*** for a triangular piece of the southwestern part of the state that includes El Paso, and approximately the western two-thirds of Louisiana, generally west of Baton Rouge). Began Nov. 1, 1995. Contractor: Foundation Health Federal Services. Toll-free phone: 1-800-406-2832.

Regions 3 and 4 (Florida, Georgia, South Carolina, Alabama, Tennessee, Mississippi, the eastern third of Louisiana, which includes New Orleans and Baton Rouge, and a small part of northeastern Arkansas that's in the Naval Hospital, Millington, Tenn. service area). Began July 1, 1996. Contractor: Humana Military Healthcare Services. Toll-free phone: 1-800-444-5445 (Beneficiary Services); 1-800-333-4040 (Health Care Finder); 1-800-403-3950 (Routine Claims).

Regions 7 and 8 (Arizona, Nevada, New Mexico, Colorado, Wyoming, Utah, most of Idaho, Montana, North and South Dakota, Kansas, Nebraska, Minnesota, Iowa, Missouri—***except*** for the St. Louis area and that piece of southwestern Texas which includes El Paso). Began April 1, 1997. Contractor: TriWest Healthcare Alliance, of Phoenix, Ariz. Toll-free phone: 1-888-874-9378. (***Note***: That's a 1-888 toll-free number.)

Region 1 (Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, Delaware, Maryland, New Jersey, New York, Pennsylvania, the District of Columbia, part of Northern Virginia, and a small part of eastern West Virginia). Toll-free phone: 1-800-578-1294.

Region 2 (North Carolina and most of Virginia, ***except*** a small part of northern Virginia). Toll-free phone: 1-800-493-1613.

Region 5 (Michigan, Wisconsin, Illinois, Indiana, Ohio, Kentucky, a small part of Tennessee, the St. Louis area in Missouri, and most of West Virginia, ***except*** for a small section of the eastern part of the state that will be included in Region 1). Toll-free phone: 1-800-493-1613.

TRICARE Overseas. TRICARE Prime and TRICARE Standard are offered to service families overseas. Networks of providers for the Prime health care option are developed by local military medical facilities in overseas areas. (See details about TRICARE overseas at the end of this chapter.)

Who's Eligible For TRICARE?

In order to use TRICARE, you must be eligible to use CHAMPUS, and you must be listed in the Defense Department's DEERS (Defense Enrollment Eligibility Reporting System) computerized database as being eligible for military health care benefits. (For more details about DEERS, see the "Who's Covered?" section.)

TRICARE-eligible people include: eligible family members of active-duty service members; military retirees and their eligible family members; surviving eligible family members of deceased active or retired service members; wards and pre-

adoptive children; and some former spouses of active or retired service members who meet certain length-of-marriage rules and other requirements. (See the "Who's Covered" chapter for more details.)

Also eligible are certain family members of active-duty service members who were court-martialed and separated for spouse or child abuse; certain abused spouses, former spouses, or dependent children of service members who were retirement-eligible but lost that eligibility as a result of abuse of the spouse or child; and spouses and children of North Atlantic Treaty Organization (NATO) nation representatives, under certain circumstances.

Also, in order to use TRICARE Prime or Extra, you must live in an area where TRICARE is in operation and a civilian provider network has been established to support the program. The program is in place in many regions now and is expected to be implemented nationwide by mid-1998.

Who's *Not* Eligible For TRICARE?

1. Most persons who are eligible for Medicare because of age (except active-duty family members). People who are Medicare-eligible because of disability or end-stage kidney disease, and are under 65, may retain TRICARE eligibility until they reach age 65, but they must be enrolled in Medicare Part B.

1. Persons who are eligible for benefits under CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs).

While active-duty service members are not eligible for benefits under TRICARE, they will be enrolled automatically in TRICARE Prime, and will be able to use the local military and civilian provider network, with necessary authorization. Their health care will remain the top priority of the military health care system, and they'll be first to be allowed to sign up with primary care managers at military medical facilities. The cost of their authorized civilian health care will be paid by the service medical facilities. The Coast Guard and Public Health Service have pre-authorization systems for non-federal medical care.

What Will TRICARE Cost?

One feature of TRICARE is a uniform benefit and fee structure that will be the same for most people once TRICARE is operational in all parts of the country. On the next two pages are tables showing some of the costs associated with the three TRICARE options.

TRICARE Costs

The tables on this page and the next page provide examples of cost-shares for families under each of the three TRICARE options. The listed fees are subject to change. The pages following these tables contain more information on costs.

Active-Duty Family Members:

	TRICARE Prime E-1—E-4	TRICARE Prime E-5 & up	TRICARE Extra	TRICARE Standard
Annual Deductible	None	None	$150/individual or $300/family for E-5 & above; $50/$100 for E-4 & below	$150/individual or $300/family for E-5 & above; $50/$100 for E-4 & below
Civilian Outpatient Visit	$6/visit	$12/visit	15% of negotiated fee	20% of allowable charge
Civilian Inpatient Admission	$11/day ($25 minimum)	$11/day ($25 minimum)	Greater of $25 or $9.90/day	Greater of $25 or $9.90/day
Civilian Inpatient Mental Health	$20/day	$20/day	$20/day	$20/day

Retirees, Their Family Members, and Others:

	TRICARE Prime	TRICARE Extra	TRICARE Standard (CHAMPUS)
Annual Deductible	None	$150/individual or $300/family	$150/individual or $300/family
Annual Enrollment Fees	$230/individual $460/family	None	None
Civilian Provider Co-Pays:		20% of negotiated fees	25% of allowed charges
Outpatient Visit	$12		
Emergency Care	$30		
Mental Health Visit	$25		
Civilian Inpatient Cost-Share	$11/day ($25 minimum)	Lesser of $250/day or 25% of billed charges plus 20% of allowed pro-fessional fees	Lesser of $360/ day or 25% of billed charges plus 25% of allowed professional fees
Civilian Inpatient Mental Health	$40/day	20% of institutional & professional charges	Lesser of $137/ day or 25% of institutional & professional charges

Point-of-Service

If you're a TRICARE Prime enrollee, you also have what's called a "***point-of-service*** ***(POS) option***. This means that you can choose to get TRICARE-covered non-emergency services outside the Prime network of providers without a referral from your Primary Care Manager and without authorization from the Health Care Finder (HCF). However, if you choose to get care under the POS option, there's an annual deductible (for both inpatient and outpatient care) of **$300** for an individual and **$600** for a family. After the deductible is satisfied, your cost-share will be **50 percent** of the TRICARE allowable charge. Any additional charges by non-network providers are also your responsibility: up to 15 percent above the allowable charge, as permitted by law. POS cost-sharing may also apply to services you received from a Prime network provider if you didn't get the required advance authorization for the care.

Because of the increased costs associated with point-of-service care, you should seriously consider contacting your Primary Care Manager (PCM) to get authorization ***before*** getting care outside the network.

The POS option does not apply to TRICARE Extra or TRICARE Standard.

Catastrophic Cap

There's an upper limit, or "catastrophic cap," on what you'll have to pay for health care under TRICARE Prime, for Prime enrollment fees, inpatient and outpatient cost-shares, and co-payments for such things as visits to the doctor (there's also a cap on expenses under TRICARE Extra and TRICARE

Standard; see the "How Much Will It Cost?" chapter for details). For active-duty families enrolled in Prime, it's $1,000 per fiscal year (Oct. 1 through the following Sept. 30); for all other Prime enrollees, it's $3,000 per enrollment year, ***unless*** you get care on your own ***without*** a referral from your TRICARE Prime PCM and ***without*** an authorization from the HCF (this is called using the "point-of-service," or "POS" option, which is explained above). If you do that, your POS medical expenses will not be "capped." *For more details about cost caps, check with your HBA/TSC.*

Remember:

The catastrophic cap applies only to allowable charges for covered services. There's no annual cap on charges for services that aren't covered, or on the yearly accumulation of what non-participating providers of care may bill you above the allowable charges for the care you received.

TRICARE Extra

In the TRICARE Extra program, when you receive care from an Extra network provider, you get a discount on cost-sharing, with no claim-filing. You don't enroll, and may use Extra on a case-by-case basis just by using the network providers.

The annual outpatient deductibles for TRICARE Extra are the same as for TRICARE Standard: for the families of active-duty E-4s and below, $50 for one person or $100 for a family per fiscal year. For all others, the deductible is $150 for one person or $300 for a family.

In general, after the annual outpatient deductible has been satisfied, the cost-share for care under TRICARE Extra for an active-duty family member will be 15 percent of the fee for which the TRICARE Extra network provider has contracted to provide the medical service or supply. All other eligible persons will pay a 20 percent cost-share of the contracted fee.

There are a few exceptions to the Extra cost-sharing percentages. (See the cost charts on previous pages.)

In addition to what's on the charts, the ***ambulatory surgery*** cost is $25 for active-duty families and 20 percent of the contracted fee for all others.

There's an annual "catastrophic cap" on how much families will have to pay for their covered care under TRICARE Extra. It's the same as for TRICARE Standard. (See the "How Much Will It Cost?" chapter for details.)

TRICARE Standard (CHAMPUS)

What's now called TRICARE Standard in many parts of the country is the same as the standard CHAMPUS program that has been serving military families for more than 30 years. Coverages, deductibles, cost-shares and claim filing rules are the same. Annual outpatient deductibles are the same as for TRICARE Extra. As with Prime and Extra, there's an annual "catastrophic cap" on costs. (See the "How Much Will It Cost?" chapter for more information.)

What Are the Priorities for Care in Military Hospitals?

The policy established by the Assistant Secretary of Defense for Health Affairs in August 1996 created the following priorities for health care in uniformed services medical treatment facilities:

1. Active-duty service members;
2. Active-duty family members ***who are enrolled in TRICARE Prime*** (for the purpose of determining access priority, survivors of military sponsors who died on active duty ***who are enrolled in TRICARE Prime*** are included in this priority group);
3. Retirees, their family members and survivors ***who are enrolled in TRICARE Prime***;
4. Family members of active-duty service members ***who are NOT enrolled in TRICARE Prime*** (for the purpose of determining access priority, survivors of military sponsors who died on active duty who are ***not*** enrolled in TRICARE Prime are in this priority group);
5. All other eligible persons.

Will TRICARE Exclude Retirees from Military Hospitals?

Eligible retirees, their family members and survivors who are enrolled in TRICARE Prime should have improved access to military hospitals. Those who decide not to enroll in Prime may find their opportunities for space-available care reduced, because most of the space at military hospitals and clinics will be devoted to TRICARE Prime enrollees.

TRICARE Overseas

Active-duty military families who live overseas will also be able to choose how to get their health care under TRICARE. They'll have two options: **TRICARE Prime** and **TRICARE Standard**.

Under **TRICARE Prime**, active-duty eligible families who live overseas must enroll as they would stateside. Effective Oct. 1, 1997, enrollment in TRICARE Prime for active-duty families overseas will not be automatic. Military sponsors must take action to enroll their families in Prime. Active-duty families will pay no enrollment fees, cost-shares or deductibles while overseas.

Prime enrollees will have access to both military medical facilities and to networks of local civilian providers put together by the commanders of military medical facilities. Wherever possible or available, most of their care will be provided by their Primary Care Manager (PCM) to whom they'll be assigned, and, when necessary, will have access to specialized care recommended by the PCM. Regional military service centers will provide Prime beneficiaries authorization for care not provided by the PCM, upon the PCM's referral.

The extent of provider networks will depend on the area—but even if a network is not available in a given location, enrolled active-duty families will still have their cost-shares and deductibles waived when authorized by the regional military service center upon a PCM's referral. However, beginning Oct. 1, 1997, if an overseas family member who's enrolled in Prime uses a ***non-network*** provider of care ***without getting an advance authorization from the regional military service***

center, cost-shares and deductibles will apply. And, they'll be ***point-of-service*** cost-shares and deductibles.

TRICARE Standard (CHAMPUS) is available to overseas families who choose not to enroll in Prime. Benefits and procedures are the same as in the U.S. (See the chapter titled "How to File a Claim" for instructions on claim filing and claims mailing addresses.)

The rest of this handbook is devoted to discussions of the various aspects of using TRICARE Standard. For example, see the chapter called "How Much Will It Cost?" for detailed information about the costs associated with using TRICARE Standard, including a discussion of the "catastrophic cap" on patients' costs for covered care.

TRICARE Standard in a Nutshell

TRICARE Standard is what for years has been called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The name has been changed to TRICARE Standard—one of the three TRICARE options that's available to people in most parts of the country now, and should be available everywhere by mid-1998. The rest of this handbook concentrates on TRICARE Standard.

TRICARE Standard shares most of the costs of care from civilian hospitals and doctors when you can't get care through a military hospital or clinic. But there are certain important things you need to know about TRICARE Standard before using it.

- The most comprehensive and lowest cost medical care is available from military medical facilities. Also, TRICARE Standard recognizes different categories of eligible persons for whom available benefits and costs vary.
- While you may be entitled to use military medical facilities, you may be denied access based on space availability.
- Some people are not eligible for TRICARE Standard, such as active-duty service members, dependent parents and parents-in-law, and most persons who are eligible for Medicare hospitalization insurance (Part A) because

they've turned 65. (See the section called "Who's Covered?" for details.)

- TRICARE Standard is not free. You must pay part of your medical costs, as well as everything TRICARE Standard doesn't cover. (See the section called "How Much Will It Cost?" for cost information.)
- TRICARE Standard does not cover all health care. There are special rules or limits on certain care, and some care is not covered at all. (See the sections on "What's Covered?" and "What's Not Covered?" for information.)
- TRICARE Standard pays for only medically necessary care and services that are provided at an "appropriate level of care." Claims for services that don't meet this definition will be denied.
- Your physician must be listed by the regional contractor as an authorized provider of care under TRICARE Standard for the government to share the cost of care you receive from him/her. ***Being "authorized" is not the same as being a "participating" or "non-participating" provider of care under TRICARE Standard***. (See the chapter titled "Where to Get Care" for discussions of authorized providers as well as participation and non-participation.)
- You or your provider must file claims before TRICARE Standard can pay its share of the bills. For your sake, it's important to fill out the claim form correctly and to include any necessary paperwork. (See the section on "How to File a Claim" for more information.)
- Equally important, all TRICARE Standard-eligible persons must be enrolled in the DEERS computerized eligibility-

checking system before TRICARE Standard claims can be paid. (See the last part of the "Who's Covered?" section for more information about DEERS.)

- The section called "Tips on Using TRICARE Standard" has information that will help you use your health benefits. The most important one is to get to know your Health Benefits Adviser (HBA), Health Care Finder (HCF), and others at your TRICARE Service Center (TSC). Their job is to help you get the medical care you need, at the best price and in the most convenient manner. There are HBAs at many military hospitals and clinics; and TRICARE Service Centers are located throughout the regions served by the various TRICARE contractors. In the back of this handbook, in the section called "Uniformed Services Medical Facilities," there's a list of military hospitals and clinics, by state and country.

One last note: In these times of rising medical costs, it's especially important to use your health benefits only when you really need to. Although it may be more difficult in an age of reduced resources and base closures, try to use military hospitals and clinics whenever possible. They save money for you and the government. By using your health benefits wisely, you help make sure the funds will be there when needed.

Who's Covered?

TRICARE Standard is a health benefits program for all seven uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service and the National Oceanic and Atmospheric Administration.

Here's a list of who's covered by TRICARE Standard:

- **Husbands, wives and unmarried children** of active-duty service members. (See details on the next two pages for eligibility of all unmarried children.)
- Retirees, their husbands or wives, and unmarried children;
- **Unremarried husbands and wives and unmarried children** of active-duty or retired service members who have died.

Note:

Family members of active-duty service members who died while on active duty, and who were on active duty for at least 30 days before death, will continue to be treated as active-duty family members for TRICARE Standard cost-sharing purposes for pre-existing medical conditions for one year after their active-duty sponsor dies.

- **Husbands, wives and unmarried children of reservists** who are ordered to active duty for more than 30 consecu-

tive days (they are covered only during the reservist's active-duty tour) or reservists who die on active duty;

- **Husbands, wives and unmarried children of reservists** who are injured or aggravate an injury, illness or disease during, or on the way to, active-duty training for a period of 30 days or less, or a period of inactive-duty training, and who die as a result of the specific injuries, illnesses or diseases;

- **Former spouses of active or retired military** who were married to a service member or former member who had performed at least 20 years of creditable service for retirement purposes at the time the divorce or annulment occurred. The former spouse must also meet the following requirements:

  1. Must not have remarried;
  2. Must not be covered by an employer-sponsored health plan;
  3. Must not be eligible for Part A of Medicare due to age, ***except*** under certain conditions. (See the paragraphs in this section titled "Medicare and TRICARE Standard.")
  4. Must not be the former spouse of a NATO member; and
  5. Must meet the requirements of one (not all) of the following three situations:

Situation 1:

Must have been married to the SAME member or former member for at least 20 years, and at least 20 of those married years must have been creditable in determining the member's eligibility for retirement pay. If the date of the final decree of divorce or annulment was on or after Feb. 1, 1983, the former spouse is eligible for TRICARE coverage of health care which is received after that date. If the date of the final decree is before Feb. 1, 1983, the former spouse is eligible for TRICARE coverage of health care received on or after Jan. 1, 1985.

Situation 2:

Must have been married to the SAME military member or former member for at least 20 years, and at least 15—but less than 20—of those married years must have been creditable in determining the member's eligibility for retirement pay. If the date of the final decree of divorce or annulment is ***before April 1, 1985***, the former spouse is eligible only for care received on or after Jan. 1, 1985, or the date of the decree, whichever is later.

Situation 3:

Must have been married to the SAME military member or former member for at least 20 years, and at least 15—but less than 20—of those married years must have been creditable in determining the member's eligibility for retirement pay. If the date of the final decree of divorce or annulment is ***on or after***

Sept. 29, 1988, the former spouse is eligible only for care received for one year from the date of the decree.

Upon completion of the period of eligibility for TRICARE, explained in Situation 3 above, a former spouse is eligible for the ***Continued Health Care Benefit Program (CHCBP).***

Continued Health Care Benefit Program

CHCBP is intended to provide benefits similar to TRICARE Standard for a specific period of time (18-36 months) to former service members and their family members, some unremarried former military spouses, and emancipated children (living on their own), who enroll and pay quarterly premiums. The quarterly premiums in fiscal year 1997 are $933 for one person and $1,996 for a family. The premiums are based on comparable Federal Employee Health Benefit Program rates paid by employees and the agencies they work for, plus an administrative fee of up to 10 percent. Benefits are like those in the basic TRICARE Standard program.

Eligible persons must enroll in CHCBP within 60 days after separation from active duty or loss of eligibility for military health care. The Defense Department has chosen a contractor to administer CHCBP, including enrollment and updates of the DEERS database. The contractor will accept applications for enrollment and checks for the first three months' coverage, and will send a letter of acceptance, which will serve as proof of enrollment when a person seeks care. (See the section at the end of this chapter for more about DEERS.)

You may call the contractor toll-free at 1-800-809-6119 for more information. Or, you may write to: CHCBP Administrator, P.O. Box 1608, Rockville, MD 20849-6119.

Also, contact your Health Benefits Adviser for more details, and see your military personnel office for eligibility determinations.

- **Unmarried children up to age 21** are covered by TRICARE. Children (including stepchildren ***who are adopted by the sponsor***) are still covered by TRICARE even if the spouse gets divorced or remarried. But in the case of a stepchild who was not adopted by the sponsor and the marriage ends in divorce, the stepchild loses eligibility on the date the divorce decree is final. It should be emphasized that stepchildren don't have to be adopted by the sponsor to be covered by TRICARE while the sponsor and the mother or father of the stepchildren remain married. A child aged 21 or older may be covered if he or she is severely disabled and the condition existed prior to the child's 21st birthday. A child may also be covered up to the 23rd birthday if he or she is in school full-time.

- A relatively new group of TRICARE eligibles is **dependents placed in the custody of a service member or former member**, either by a court or by a recognized adoption agency, in anticipation of legal adoption by the member. TRICARE eligibility is effective July 1, 1994 if the child is placed by a court. A child placed by a recognized adoption agency is eligible effective Oct. 5, 1994.

- **Illegitimate children** of current or former service members or their spouses may be eligible for TRICARE benefits

under certain conditions. Check with your Health Benefits Adviser (HBA), Health Care Finder (HCF) or TRICARE Service Center (TSC).

- Certain family members of active-duty service members who were court-martialed and separated for spouse or child abuse. The victims of the abuse within the family are eligible for treatment of illnesses and injuries related to the abuse for one year from the date of the sponsor's separation from the service. Cost-sharing will be the same as for other active-duty families.
- Certain abused spouses, former spouses and dependent children of service members who were eligible for retirement but had that eligibility taken away as a result of abuse of the spouse or child. This benefit is effective for medically necessary services and supplies provided under TRICARE Standard (CHAMPUS) on or after Oct. 23, 1992. It isn't limited to one year of eligibility (as is the category described immediately above), nor is it limited to illnesses and injuries resulting from the abuse.
- Spouses and children of North Atlantic Treaty Organization (NATO) nation representatives who are officially accompanying the NATO nation representatives while stationed in or passing through the U.S. on official business. These family members are eligible for outpatient benefits only (including ambulatory surgery). They are not listed in the DEERS files, and should check with their nearest Health Benefits Adviser for assistance before getting care or filing claims.

Former Active-Duty Members and Families

In addition to the categories of TRICARE-eligible persons listed above, Congress has granted eligibility for limited periods of TRICARE benefits to several categories of ***former*** active-duty service members and their eligible family members (this is called the "Transitional Assistance Management Program," or "TAMP"). Here's a list of the benefit periods and those who qualify for them:

- **Sixty days** for regular Department of Defense military members who were on active duty on Sept. 30, 1990, and who are involuntarily separated with fewer than six years of active service, and their eligible family members. The involuntary separation must occur during the nine-year period beginning Oct. 1, 1990.
- **One hundred-twenty days** for regular Department of Defense military members who were on active duty on Sept. 30, 1990, and who are involuntarily separated with six or more years of active service, and their eligible family members. The involuntary separation must occur during the nine-year period beginning Oct. 1, 1990.

Eligibility is determined by the individual service branches. They also provide eligibility information to the DEERS (Defense Enrollment Eligibility Reporting System) computer data files. TRICARE contractors then check the DEERS files for eligibility status when processing claims.

TRICARE Standard claims for persons who fall into the above TAMP categories will be cost-shared as if the sponsors and family members were active-duty dependents.

Voluntary Separation Benefits

Under the services' program to encourage certain members to leave active duty voluntarily, those who decide to accept either the lump-sum "Special Separation Benefit" (SSB) or the "Voluntary Separation Incentive" (VSI) options when they separate will be entitled to all of the benefits provided for involuntarily separated members. These benefits include the transitional health care benefits listed above. Members who choose the SSB or VSI options (and their families) may continue their health benefits by enrolling in the Continued Health Care Benefit Program (CHCBP). (See the CHCBP section earlier in this chapter for more details, and check with your HBA/TSC.)

TRICARE Standard Does Not Cover

- Active-duty service members;
- Dependent parents and parents-in-law. (They are, however, eligible for care in military medical facilities on a space-available basis.)

ID Cards

To use TRICARE benefits, you must have a valid ID card issued by the uniformed services. The ID card says on the back, in the "Medical" block, whether you are eligible for medical care from military or civilian sources. Children under 10 can normally use either parent's ID card, but must be enrolled in DEERS. These children should have an ID card of their own when in the custody of a parent who is not eligible for benefits.

Newborns who need a nonavailability statement must be listed in the DEERS computer files even though they don't have an ID card.

Medicare and TRICARE

If you are eligible for Medicare (Part A) and are a retiree, survivor or family member of a retiree, you are not eligible for TRICARE in most situations (for exceptions, see note below).

Remember:

Even if you are not eligible for Medicare on your own, you may be eligible through your husband, wife or parent if they have worked and paid taxes under the Social Security system. If so, you are not covered by TRICARE. And it doesn't matter whether you've applied for Medicare. It matters only if you are eligible for Medicare (Part A).

Note:

Congress has re-established TRICARE eligibility for persons under age 65 who lost their eligibility when they became entitled to Medicare Part A because of disability or because of end-stage kidney disease, and who are enrolled in Medicare Part B. The law, which makes TRICARE pay after Medicare for these eligible persons, establishes the policy's beginning eligibility date of Oct. 1, 1991.

For the latest information on this eligibility, including details on filing claims with TRICARE after Medicare

has paid, and updating your eligibility status with DEERS, check with your nearest HBA/HCF/TSC.

Remember:

If you become eligible for Medicare because of disability or end-stage kidney disease, you must report that eligibility to your nearest military personnel office.

Medicare eligibility begins on the first day of the month in which you become eligible. However, if your 65th birthday falls on the first day of the month, then your Medicare Part A eligibility begins on the first day of the preceding month—and your TRICARE eligibility ends. (See the "Tips on Using TRICARE" section if you are almost or past age 65.)

A Social Security Administration "Notice of Disallowance" must be submitted to the uniformed service responsible for issuance of your identification card if you're not eligible for Medicare Part A, so that a new card showing TRICARE eligibility can be issued.

If you're the spouse of a retired military sponsor who has reached the age of 65 and is therefore no longer eligible for TRICARE benefits, your TRICARE eligibility is not affected until you personally become 65 years old or become eligible for Medicare Part A.

All TRICARE-eligible persons, except eligible family members of active-duty members (and except those persons described in the note on the previous page), lose their TRICARE eligibility when Medicare coverage becomes available to them.

Medicare Penalties

Persons who aren't eligible for Medicare Part A (hospital services), and are able to keep TRICARE after reaching age 65, may have to pay a penalty if they later become eligible for Medicare (such as through a spouse's eligibility) and sign up for Medicare Part B (medical insurance). Here's an actual case (with the names changed) which illustrates the problem:

Retired Army Sergeant Smith's wife is several years older than he is. She didn't work long enough under Social Security to be eligible for Social Security benefits including Medicare Part A, so the Social Security Administration issued her a "Notice of Disallowance." But, she was eligible for TRICARE benefits as the dependent of a military retiree. So, because she had been using TRICARE, she decided not to participate in Medicare Part B.

When Sgt. Smith was approved for reduced Social Security retirement benefits at age 62, Mrs. Smith was already over 65. As a result of his Social Security eligibility, she became eligible for Medicare Part A, and lost her entitlement to TRICARE.

When she then tried to sign up for Medicare Part B, she found that she would have to wait until the next open enrollment period. Also, she would have to pay a 10 percent penalty on top of the regular Medicare Part B premium. In addition, her Part B benefits would not start until July 1 of the year she was able to enroll in Medicare Part B, after she enrolled during the open enrollment period.

Persons who are affected by this situation may apply to the Social Security Administration for "equitable relief" from the penalty payments, where there is reasonable evidence that an individual was not appropriately advised by the government so that he or she could make a proper choice regarding Medicare Part B. You don't have to enroll in Medicare Part B retroactively in order to get equitable relief from the penalty payments.

Any military retirees or surviving family members who might be affected by a situation like the one described above should contact the nearest Social Security Administration office regarding Medicare penalties.

If you are the widow or widower of a service member, and remarry someone outside the uniformed services, you are no longer covered by TRICARE (unless the marriage is annulled, in which case eligibility is reinstated after the annulment).

Retired reservists and their families are covered by TRICARE after the reservist reaches age 60 and begins to receive retired pay. Check with your HBA/TSC on this.

Families of veterans with 100-percent, permanent disability, or of veterans who died from a service-connected disability may be covered by CHAMPVA as long as they are not eligible for TRICARE. These veterans—who left active duty without qualifying for a regular military retirement—must receive their care from the Department of Veterans Affairs.

Military retirees who need treatment of service-connected conditions may choose to be treated under TRICARE or to get civilian health care that's paid for by the Department of Veterans Affairs—but not both.

DEERS

You must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS) in order to receive care in uniformed services hospitals or to have claims for civilian health care processed by TRICARE. Both active and retired military sponsors and all family members must be entered in the DEERS computer data banks and shown as eligible for TRICARE benefits. This includes newborns, who must be enrolled in DEERS before claims for their care as TRICARE-eligible patients can be processed. Generally, it's the sponsor's responsibility to make sure that his or her family members are enrolled in DEERS through the nearest military personnel office. All military sponsors should ensure that the status of their families (marriage, divorce, new child, etc.) is current in the DEERS files so TRICARE claims can be processed quickly and accurately.

Note:

The military sponsor is responsible for disenrolling his or her family members from DEERS when they are no longer eligible for TRICARE (because of the marriage of a minor child, divorce of a spouse who isn't eligible for continued TRICARE benefits, enlistment of a child in the military, etc.). If the sponsor doesn't do this, and an ineligible family member improperly continues to receive care under TRICARE, the government is required by law to get back the amount it paid for such care from whomever received the money. For more information about this, read the section on recoupment of funds incorrectly paid in the chapter titled "How Much Will It Cost?"

Remember:

TRICARE doesn't make DEERS entries. That's done through the local base's military personnel office.

If you are leaving the service and are not covered under the transitional assistance programs outlined earlier in this chapter, TRICARE eligibility for the family generally ends at midnight of the day that an active-duty sponsor is discharged or leaves the service other than through retirement or death. For information about DEERS enrollment, contact the DEERS Telephone Center from 6 a.m.-5 p.m. Pacific Time, Monday through Friday, at the following numbers:

- 1-800-334-4162 (California only)
- 1-800-527-5602 (Alaska and Hawaii only)
- 1-800-538-9552 (all other states)

What's Covered?

Generally, TRICARE Standard covers most health care that is medically necessary. But there are special rules or limits on certain types of care. And some types of care are not covered at all.

Remember:

Just because your military or civilian doctor tells you that you need certain care doesn't mean that TRICARE Standard can help pay for it. If you're not sure whether TRICARE Standard covers a service or supply, contact your Health Benefits Adviser, your TRICARE Service Center or your TRICARE contractor. They can advise you about covered services, but can't guarantee that TRICARE Standard will share the cost. That determination comes later, after the claim has been submitted.

In general, TRICARE Standard helps pay most doctor bills for inpatient and outpatient care that's medically necessary and is not considered investigational or experimental.

TRICARE Standard helps pay most hospital bills for semi-private rooms, meals (including special diets), diagnostic tests and treatment. It covers medical supplies such as bandages and syringes. And, it helps pay for covered care at some health care centers other than hospitals. For example, you might need to use a residential treatment center for an emotionally disturbed child, or a drug detoxification and rehabilitation center. The

types of other health care centers covered by TRICARE Standard are listed in the chapter titled “Where to Get Care.”

Special Benefits and Certain Limits

Alcoholism (and Other Substance Use Disorders)

Treatment for alcoholism or the abuse of other substances is considered mental health treatment by TRICARE Standard and is subject to the same pre-authorization requirements as mental health care. Alcoholism (or other substance use disorder) treatment includes:

Hospital Care

TRICARE Standard helps pay for up to seven days of detoxification in an alcohol (or substance use disorder) rehabilitation facility. This may be needed when the patient suffers from delirium, confusion, trauma, unconsciousness or malnutrition. The seven days are included in the maximum of 30 or 45 days (depending on the patient’s age) of inpatient mental health care allowed per fiscal year, but don’t count toward the 21 days of rehabilitation mentioned below.

Rehabilitation Stays

In addition to the seven-day detoxification period mentioned above, TRICARE Standard helps pay for up to 21 days of rehabilitation (this is included in the 30 or 45 days of inpatient mental health care allowed per fiscal year). But it is limited to 21 days per 365-day period and only three inpatient admissions during the person’s life. And it’s covered only in a

hospital or special treatment center whose alcohol or other substance use disorder rehabilitation facility has entered into a participation agreement with TRICARE. Before getting care, check with the TRICARE claims processor to make sure the hospital or center is approved by TRICARE.

Treatment for alcoholism or other substance use disorders includes "partial hospitalization" in an authorized substance use disorder rehabilitation facility. Partial hospitalization is when the patient spends at least three hours a day at the facility, five days a week (the treatment may also occur on weekends or in the evening), then goes home at night. TRICARE Standard shares the cost of this treatment up to 21 days at a pre-determined, all-inclusive *per diem* rate.

Outpatient Care for Alcoholism or Other Substance Use Disorders

It's covered for up to 60 visits over the course of a "benefit year," beginning the day the person starts receiving the rehabilitation phase of treatment.

Family therapy is covered for up to 15 visits per year, also beginning the day the therapy starts.

Waivers to the limits on care can be granted if the continued care meets certain requirements. This is true of both inpatient care and partial hospitalization.

Ambulances

TRICARE Standard cost-shares ambulances only when medically necessary; that is, the patient's condition does not

allow use of regular, private transportation or taxis, “medicabs” or “ambicabs.” And, it must be needed for a medical condition that is covered by TRICARE Standard.

TRICARE Standard shares the cost of an ambulance for transfers between any two points determined to be medically necessary for the covered medical condition, such as from home to hospital, or between hospitals. If the ambulance is ordered from a military hospital, TRICARE Standard can’t pay for it—the military hospital must pay. Ambulance transfers between hospitals are currently cost-shared on an inpatient basis. Ambulance service to or from a hospital (for example, between the hospital and your home) is still cost-shared on an outpatient basis. Check with your HBA or TRICARE Service Center (TSC) if you have questions about this.

Any Care that Lasts a Long Time

Any type of care that goes on for a long time (over a period of days or weeks, etc.), such as physical therapy, regular medication or mental health services, may need certain reviews and paperwork to be completed during the course of treatment. Be sure to check with your HBA/TSC.

Biofeedback

Only certain types of therapy (electrothermal, electromyograph and electrodermal) are covered and only when the patient’s condition is documented as not having responded to other forms of conventional treatment. There are other limits as well. Check with your HBA/TSC before beginning biofeedback therapy.

Cancer Test Project Expansion

A Department of Defense/National Cancer Institute demonstration project for breast cancer that has allowed TRICARE patients access to promising cancer therapies has been expanded to include other cancers as well.

The expansion of the test permits eligible patients who meet clinical criteria to participate in Phase II and Phase III clinical trials sponsored by the National Institutes of Health's National Cancer Institute (NCI).

The original demonstration, which began in 1994, allowed CHAMPUS to reimburse the costs for eligible patients who requested treatment for breast cancer under NCI-sponsored clinical trials. The expansion to other cancers was effective Jan. 1, 1996. The demonstration project will continue through 1998.

Patients who want to participate in an NCI-sponsored clinical trial must first have their physician confirm with the proper TRICARE contractor for the demonstration (currently Palmetto Government Benefits Administrators—or "PGBA") that the proposed trial falls under the terms of the demonstration project. The physician must then receive authorization from PGBA for the patient to be evaluated at the institution conducting the study. If the patient is eligible for the study and agrees to participate, the physician must contact PGBA for treatment authorization.

PGBA staff members are available to answer questions from patients about the demonstration project and to provide treatment authorization for providers of care. PGBA's toll-free telephone number is 1-800-779-3060.

Participating institutions include a nationwide network of 2,000 facilities, including comprehensive and clinical cancer centers, community hospitals and practices, and military medical facilities.

Normal TRICARE cost-shares and deductibles, and other rules, policies and regulations, will apply for demonstration participants. Transportation costs are borne by the patient.

Cardiac Rehabilitation

Certain cardiac rehabilitation programs are covered for inpatient or outpatient care. Services and supplies must be provided by TRICARE Standard-authorized hospitals and ordered by physicians as treatment for patients who have experienced any of the following conditions or events during the preceding 12 months:

- Myocardial infarction (heart attack);
- Coronary artery bypass graft;
- Coronary angioplasty (surgical reconstruction of coronary blood vessels);
- Percutaneous transluminal coronary angioplasty (use of balloon catheter inserted into a coronary blood vessel to flatten plaque against the artery wall);
- Chronic stable angina (chest pain)—subject to certain limitations.

Outpatient cardiac rehab treatment is limited to 36 sessions per cardiac event, and in some cases, one series of treatments in a calendar year. There are other limits as well. TRICARE

Standard won't cost-share programs designed primarily for lifetime maintenance that are performed at home or in medically unsupervised settings. Check with your HBA/TSC for other restrictions.

CT Scans and Magnetic Resonance Imaging (MRI)

Computerized tomography can be cost-shared by TRICARE Standard. But the doctor must ***first*** try other diagnostic tests that can give the desired medical information and are less expensive and non-invasive (that is, involve no insertion of an instrument or foreign material into the body), unless the CT scan is considered the most appropriate diagnostic test.

Magnetic resonance imaging (MRI) is a "no-radiation" way of producing high quality images of cross-sections of the body in order to spot internal abnormalities or diseases. TRICARE Standard cost-sharing of MRI is limited to medically necessary and appropriate use of the procedure on soft tissue areas within the body, using only MRI equipment approved by the Food and Drug Administration and used within its guidelines. TRICARE Standard won't cost-share MRI for certain kinds of patients, such as pregnant women or acutely ill patients on certain kinds of life-support systems. Contact your HBA for more details on coverage limits and requirements for MRI, or check with the TRICARE contractor for your state.

Dental Care

Important Note:

The dental coverage discussed below is ***not*** *part of, and has nothing to do with, the uniformed services' TRICARE Active-Duty Family Member Dental Plan. (See the chapter later in the handbook for information on the TRICARE Active-Duty Family Member Dental Plan.)*

For the most part, TRICARE Standard does not cover dental care. The only time it's covered is when it's a medically necessary part of medical treatment that is covered by TRICARE Standard. And in such cases, you must get an okay from the CHAMPUS dental claims processor in areas where TRICARE is not yet operating, or from the TRICARE contractor in a region where TRICARE is in operation, before you get care from a dentist (oral surgery does not need advance authorization). (See "How to Get Approval for Dental Care" in this chapter.) TRICARE covers dental care only when:

- It is a necessary part of other medical care that is covered. For example, an oral surgeon may have to remove broken teeth as part of the medical treatment for an injury.
- Or, a medical problem requires that you must go into the hospital as an inpatient for dental work. For example, people with blood disorders such as hemophilia may be hospitalized for dental treatment so that any bleeding caused by the dental work can be stopped. In this case, TRICARE Standard pays for only the hospital part of the bill, not for the dental inpatient care, and for any care that is medical, not dental. For example, anesthesia used in

conjunction with the dental work is not cost-shared by TRICARE Standard.

Dental Plan for Retirees

In early 1998, the Defense Department will offer a TRICARE retiree dental program to retired military members (including the U.S. Coast Guard), their eligible family members, and unremarried surviving spouses of deceased military retirees (there'll be no age limits on eligibility). The program will feature a variety of diagnostic, preventive, restorative, endodontic, periodontic and oral surgery services, at specified levels of cost-sharing.

The program will be paid for by premiums collected from enrollees through payroll deduction from those who receive retired pay. Those who don't receive retired pay will be billed directly for premiums by the contractor that's selected to run the program.

Initial enrollment in the program will be for at least 12 months. Enrollees must submit a payment equal to three months' worth of premiums with their initial enrollment application. After the first 12-month period, enrollees may choose to stay enrolled on a month-to-month basis.

Some of the covered services under the program (mostly diagnostic and preventive services) won't require a payment by enrollees. Other services will require enrollees to pay cost-shares of 20 or 40 percent. There'll be a $50 annual deductible before government cost-sharing begins.

Not counting the diagnostic and preventive services, the government will share the cost of covered services up to $1,000 per enrolled individual per year of enrollment.

More information will be available as the starting date for the program approaches. Check with your HBA or TRICARE Service Center for details.

Dental Plan for Reservists

Effective Oct. 1, 1997, the Defense Department will make available to all members of the Selected Reserve of the uniformed services a dental program called the TRICARE Selected Reserve Dental Program (TSRDP). This plan will offer diagnostic, preventive, oral surgery and emergency dental services. Coverage will be limited to reservists only; family members will not be covered.

Reservists who want to enroll in the plan must have at least 12 months of service remaining, and must initially enroll for 12 months. After the initial 12-month period, reservists may enroll on a month-to-month basis as long as they remain eligible. Coverage will end for reservists who are called to active duty for more than 30 days (premiums paid for unused months of enrollment will be returned)—but they may re-enroll if otherwise still eligible when the active-duty period ends.

The maximum annual benefit for services under the plan is $1,000 worth of paid allowable charges per

enrollee per contract year. The government will pay 60 percent of the cost of each reservist's monthly premium. The reservist's share of the monthly premium won't be more than $25. Enrollees must submit four months' worth of premium payments with their initial enrollment form. After that, they may make monthly payments to the contractor that's chosen to operate the program. Reservists who are in "pay" billets will have their share of the monthly premium withheld from their monthly drill pay.

Reservists who want to learn more about the TSRDP may contact their reserve units or local reserve centers for information.

Drug Abuse

Treatment for drug abuse (substance use disorders) is covered on an inpatient or outpatient basis in an authorized treatment facility. Like treatment for alcoholism (see the "Alcoholism" section earlier in this chapter), it's covered under the general category of mental health treatment. (See the discussion of mental health coverage later in this chapter, and contact your nearest Health Benefits Adviser (HBA), TRICARE Service Center (TSC) or Health Care Finder (HCF) for additional details.)

Durable Medical Equipment

Durable medical equipment, like wheelchairs, hospital beds and respirators, can be cost-shared by TRICARE Standard. You can rent—or sometimes "lease/purchase" or buy—the

equipment (whichever method is least expensive for the government). A doctor's prescription specifying the particular type of equipment you need, and why—and for how long—you need it, must be sent in with your claim. Your HBA/HCF can help you find a medical supply firm or pharmacy that accepts TRICARE Standard terms. Equipment that is for general use—such as air cleaners or whirlpool baths—is not cost-shared by TRICARE Standard, even though a physician may have prescribed it. Because it can be complicated, be sure to check with the HBA/TSC before getting any durable medical equipment. And, if you live within the ZIP code zone of the nearest military hospital, check with the HBA there to see if the needed equipment is available on loan.

Remember:

The HBA/TSC can give you information, but can't guarantee payment by TRICARE Standard. ***Make sure you get the exact equipment that you ordered****. If you don't get the proper equipment, notify your HBA/TSC.*

Eye Examinations

One screening eye examination per person, per 12-month period, is authorized for active-duty families only. The exam may include a check of the internal and external structures of the eye for eye disease and signs of other disease and evaluation of the patient's vision. It may be performed by an ophthalmologist or an optometrist.

An eye exam would be covered for any TRICARE Standard-eligible person if the exam is related to a covered medical condition, such as cataracts or an eye injury.

Family Planning

TRICARE Standard Covers:

- Infertility diagnosis and treatment (remember, TRICARE Standard does not cover the active-duty sponsor);
- Intra-uterine devices (IUDs);
- Measurement for, and purchase of, contraceptive diaphragms;
- Birth control pills your doctor prescribes;
- Norplant System long-term reversible contraceptive implants;
- Tests to find out if you're pregnant—but over-the-counter self-tests are not covered;
- Sterilization—vasectomy or tubal ligation; check with your HBA/TSC for limitations.

TRICARE Standard Does Not Cover:

- Over-the-counter contraceptives—such as prophylactics (condoms) and spermicidal foams;
- Surgery to reverse sterilization;
- Artificial insemination—including sperm banks/donors, in vitro fertilization and other artificial means of conception;
- Abortions—in very limited circumstances, when the physician certifies that the life of the mother is endangered, TRICARE Standard can cover abortions; check with your HBA/TSC.

Having a Baby

Genetic Tests

Genetic tests to find out if your unborn child has genetic defects are covered. But TRICARE Standard helps pay **ONLY** if:

- You are a pregnant woman 35 years old or older, or
- You had rubella during your first three months of pregnancy, or
- You or your husband have had a child with a genetic (congenital) defect, or
- You or your husband come from a family that has a history of genetic (congenital) defects.

TRICARE Standard cannot help pay for genetic tests:

- Not ordered by a doctor;
- To tell who is the father of the child;
- To tell if your unborn child will be a boy or a girl.

Note:

Chromosome analysis in cases of infertility or where fetuses are repeatedly aborted is considered a diagnostic service, and is not subject to genetic testing limitations.

Maternity Care

If you become pregnant, TRICARE Standard helps pay for the maternity care you need. This is true during your pregnancy, delivery of the baby, and up to six weeks after the baby is born. However, if an active-duty member is discharged from the service while his wife is pregnant, TRICARE Standard does not cover any maternity care after the day of discharge, unless the family qualifies for the Transitional Assistance Management Program—or who has enrolled in the Continued Health Care Benefits Program. (See the "Who's Covered?" chapter for details.)

Remember:

"Maternity care" is the care you need because you are pregnant or for complications from pregnancy. For example, treatment for a sprained ankle during pregnancy is not maternity care. Furthermore, TRICARE Standard can share the cost only of maternity care that is covered. For example, vitamins during pregnancy are not covered. Prescription drugs related to the maternity care are covered.

TRICARE Standard handles maternity care differently from other kinds of health care. A lot depends on where you plan to have your baby.

Soon after you find out you're pregnant, decide where to have the baby. This choice determines how TRICARE Standard helps pay for maternity care. Do you plan to have the baby at a hospital or other health care center where you stay overnight? If so, you'll be an inpatient. Or do you plan to have the baby at home or at a participating TRICARE Standard-

authorized “freestanding” birthing center or hospital-based birthing room? If so, you’ll be an outpatient.

Inpatient Deliveries

Do you plan to have the baby as an inpatient? If so, this section is for you, even if you don’t make it to the hospital to deliver.

First, if you live in the designated ZIP code service area (also called a “catchment area”) around a military hospital, you must plan to get all of your maternity care at that hospital. If the military hospital can’t provide all your maternity care, ask for a nonavailability statement. A nonavailability statement is a certification from the military hospital that says it can’t provide the care you need. You must get the military hospital to file a nonavailability statement electronically in the DEERS computer data bank before TRICARE Standard can help pay for your care from civilian hospitals or doctors. And you must get it before you receive the care. Check with your HBA if you aren’t sure whether your home address falls within the ZIP code zone. (See additional details about nonavailability statements in the “Where to Get Care” chapter.)

If you do need to go to a civilian hospital or doctor, it will save you money if you find one that participates in TRICARE Standard. (For a more complete discussion of providers who do or don’t participate, see the “Where to Get Care” chapter.)

Providers Who Participate in TRICARE Standard

Hospitals and doctors who participate in TRICARE Standard receive the TRICARE Standard "allowable charge" for their services. However, you must still share some of the costs as follows:

- If you're the wife of an active-duty member, TRICARE Standard pays for all of the covered maternity care from your doctor. For the hospital's costs, you must pay a small amount for each day that you're in the civilian hospital. This daily rate changes over time. In fiscal year 1997, it's $9.90. But no matter how short your hospital stay, you must pay at least $25.
- For unmarried daughters of active-duty members and retirees, TRICARE Standard will share covered maternity costs for the mother, but not for the baby. After delivery, the baby is not eligible for TRICARE Standard, unless the father is an active-duty member or a retiree and a court recognizes him as the father.
- If you are a retiree or the wife of a retiree, you'll pay the lesser of 25 percent of the hospital's billed charges or a fixed daily amount (currently $360, but subject to change) under the TRICARE Standard "diagnosis-related group" (DRG) payment system. TRICARE Standard pays the rest. Or, in the few areas or hospitals that don't have the DRG payment system, you'll pay 25 percent of the allowable maternity costs, and TRICARE Standard will pick up the other 75 percent.
- Newborn infants will not be treated as separate patients for the first three days of their stay in a hospital that comes

under the DRG payment system. After that, they will be charged a cost-share, whether the mother continues to be hospitalized or not. Infants who are delivered in a hospital that does not come under the DRG system (such as hospitals in Maryland) will be charged a cost-share for every day after the third day of their hospital stay, and may require a nonavailability statement (NAS). (See the "DRG Hospital Payment Rules" section in the "How Much Will It Cost?" chapter for a more complete discussion of the TRICARE Standard DRG payment system.)

Providers Who Don't Participate in TRICARE Standard

If the hospitals or doctors don't participate in TRICARE Standard, you must arrange with them to pay your bills. They may charge more than the TRICARE Standard "allowable charge."

Note:

They shouldn't charge more than the legal limit—15 percent above the TRICARE Standard allowable charge.

TRICARE Standard pays the government's share of the allowable charge for covered care. You must pay the difference, and are responsible for paying the provider's full bill, up to the legal limits.

Hospital Birthing Rooms or Centers

If you plan to have your baby in a birthing center or a hospital outpatient birthing room, TRICARE Standard can

cost-share the delivery and all of your maternity care at inpatient rates if you're an active-duty or NATO family member (the care will be cost-shared at outpatient rates for all other TRICARE-eligible persons). That's true even if you don't stay in the hospital's outpatient birthing room for 24 hours. Check with your HBA/TSC or claims processor to make sure the center is approved by TRICARE Standard. (See the "Outpatient Deliveries" section immediately following for information about freestanding birthing centers.)

Maternity Claims

Under the "diagnosis-related groups" (DRG) payment system, separate claims must be filed for the mother and the newborn child. Your hospital will take care of this for you.

Outpatient Deliveries

Do you plan to have the baby as an outpatient? If so, TRICARE Standard helps pay for your maternity care on an outpatient basis, as follows:

The Outpatient Deductible

As with all outpatient care, you are responsible for the deductible for the year—October 1 through September 30. The claims processor subtracts your deductible from TRICARE Standard payments on your claims during the year, and applies amounts to your deductible from claims being processed.

Providers Who Participate in TRICARE Standard

Providers who participate in TRICARE Standard receive the TRICARE Standard allowable charge for their services. However, you still must share some of the costs, as follows:

- If you are the wife or unmarried daughter of an active-duty member, TRICARE Standard pays generally 80 percent of your covered maternity costs. You must pay the other 20 percent, unless you use a freestanding birthing center. (See the upcoming section on Freestanding Birthing Centers.) For unmarried daughters, TRICARE Standard pays none of the baby's bills, unless the father is an active-duty, retired or deceased service member, and a court recognizes him as the father.
- If you are a survivor, retiree or the wife or unmarried daughter of a retiree, TRICARE Standard pays 75 percent of your covered maternity costs. You must pay the other 25 percent.

Providers Who Don't Participate in TRICARE Standard

If the hospitals or doctors don't participate in TRICARE Standard, you must arrange with them to pay your bills. The law says they may charge up to 15 percent more than the TRICARE Standard allowable charge. TRICARE Standard pays the providers the government's share of the cost of covered care. You must pay the difference, up to the legal limit. (See a discussion of the limits on medical bills in the chapter titled "How Much Will It Cost?")

If You Plan to Deliver at Home

Even though you plan to have your baby at home, if you live in the designated ZIP code zone around a military hospital, contact the Health Benefits Adviser/TRICARE Service Center to find out if the hospital can provide inpatient maternity care. If it can't, ask for a nonavailability statement (NAS) right away!

Why? Suppose you plan to have your baby at home. But at the last minute, you decide to go to a hospital instead. Or, you might have problems with your pregnancy and need to go to a hospital. You must have the NAS before you go to the civilian hospital if TRICARE Standard is to share any of your maternity care costs.

Note:

While certified nurse midwives can be authorized TRICARE Standard providers of care, "lay" midwives (midwives who are not registered nurses) are not authorized under TRICARE Standard.

Freestanding Birthing Centers

TRICARE Standard cost-shares the use of approved freestanding birthing centers that agree to participate in TRICARE Standard. Birthing centers may be "freestanding" (separately located and not having any official connection with a "parent" institution), or they may be affiliated with, and even located at, another institution. They must be authorized as providers of care under TRICARE Standard and must have signed a participation agreement with TRICARE Standard. These birthing centers provide services for low-risk (normal)

pregnancies and are limited to the use of natural childbirth procedures. Active-duty dependents pay $25 to use them and to use hospital-based birthing rooms for outpatient deliveries. For other TRICARE-eligible persons, cost-sharing will be on a standard outpatient basis. For more information, contact your nearest Health Benefits Adviser or TRICARE Service Center.

Ambulance Costs for Maternity Care

No matter where you plan to have your baby, TRICARE Standard may share ambulance costs on an inpatient or outpatient basis. (See the section on "Ambulances" earlier in this chapter.)

Care for Your Baby

For routine newborn care, separate claims are filed, but the baby's care is paid as part of your maternity care for the first three days. After three days, the baby begins separate cost-sharing as an individual at the normal rate, and may require a nonavailability statement (NAS). (See an additional discussion of this in the section titled "Providers Who Participate in TRICARE Standard" earlier in this chapter.)

Note:

TRICARE Standard cannot cost-share the charges for grandchildren of active-duty, retired or deceased members, unless the child's father is an active-duty or retired service member.

If your baby has to stay in the hospital more than three days, or stays after you leave, or needs other than routine

newborn care while you're both still in the hospital, the baby is considered a patient in his/her own right. That is, claims must be sent in separately for the baby's non-routine care. If you live in a military hospital's ZIP code zone, and your baby must stay in a civilian hospital after you leave the civilian facility, you may need to get a nonavailability statement for the baby from the military hospital, within 15 days of your own discharge from the civilian hospital. Or, the baby may have to be transferred to the military hospital if it can provide the care.

After you both leave the hospital, your baby becomes a TRICARE Standard beneficiary in his/her own right—the baby may have already become one if his/her hospital stay lasted more than three days. That means claims for the baby's care must be sent in and TRICARE Standard shares the costs on the same basis as for anybody covered by TRICARE Standard.

Note:

Be sure to enroll your baby in DEERS as soon as possible. TRICARE Standard will deny payment on claims for the baby unless he or she is listed in the DEERS files as being eligible for TRICARE benefits.

Well-Baby Care

Babies and young children less than two years of age are covered for the well-child care described below. Well-child care is cost-shared on either an inpatient or outpatient basis, depending on whether the child is hospitalized or not. Covered care includes, with certain frequency limitations:

- Newborn examinations, PKU tests and circumcision

- History and physical examination
- Vision, hearing and dental screening (performed by a pediatrician)
- Development appraisal
- Immunization for DPT, polio, measles, mumps, rubella, etc.
- Hemophilus influenza type B vaccine
- Hepatitis B series
- Tuberculin tests
- Blood tests to check for anemia
- One blood lead-level screening
- Urinalysis

Of course, TRICARE Standard also covers other types of medical care for the child, as it would for any eligible person.

Preventive Care: *It's not yet in place as of mid-1997, but for eligible children six years of age and older, there may soon be an expanded preventive-care benefit under TRICARE Standard which would offer preventive-care services like those currently available to those who enroll in the TRICARE Prime HMO-type option. Regular cost-sharing and deductibles would apply to these preventive-care services when they're obtained under TRICARE Standard. Check with your HBA/TSC on the status of this proposed benefit.*

Hospice Care

TRICARE Standard now covers the cost of hospice care for terminally ill patients who are expected to live less than six months if the illness runs its normal course. There are no limits on custodial care and personal comfort items under hospice care rules, as there are with other types of care. Also, there are fewer restrictions than in other types of TRICARE Standard-covered care. And, TRICARE Standard pays the full cost of covered hospice care services, except for small cost-share amounts which may be collected by the hospice for such things as drugs and inpatient respite care. Check with your HBA/TSC or your TRICARE contractor for details.

Implants

Surgical implants are covered when they are of a type approved by the Food and Drug Administration.

Examples: Intraocular lenses, which are implanted in the eye after cataract surgery; cochlear implants, which are electronic instruments surgically implanted in the ear to assist in hearing; breast implants for reconstructive surgery following surgical removal of the breast; and penile implants, done to correct malformation of the male sex organ which has existed since birth; organic impotency; or the correction of what the medical profession calls "ambiguous" reproductive organs.

There are limitations to all of these procedures, so check with your HBA/TSC before having any type of surgical implant.

Mammograms and Pap Smears

Routine mammograms and pap smears are covered as diagnostic or preventive health care measures. There are certain rules regarding frequency of the procedures and as to who may provide the services. Check with your HBA/TSC.

Medical Equipment and Supplies

For medical supplies (such as needles or syringes) and medical equipment under $100 (such as crutches), a doctor's prescription must be sent in with your claim (durable medical equipment worth more than $100 also needs a prescription). Your HBA/TSC may be able to help find a medical supply firm or pharmacy that accepts TRICARE Standard terms.

Medications

Food and Drug Administration-approved medications are covered (example: the AIDS medication Zidovudine, also called "AZT" and sold under the commercial name "Retrovir"). If you aren't sure whether your medication is approved by the FDA and covered by TRICARE Standard, check with your HBA/TSC.

Note:

Medications that are available "over-the-counter"—that is, without a prescription—are not cost-shared by TRICARE, even if your physician prescribes them.

Mental Health

TRICARE Standard helps pay for psychotherapy, either in the hospital or on an outpatient basis. If your provider of care believes you need more than five psychotherapy sessions a week in the hospital, or more than two psychotherapy sessions a week as an outpatient, a TRICARE contractor must review the medical necessity for the care. Also, if you need more than 23 outpatient psychotherapy sessions in a fiscal year, approval is required. In parts of the country where TRICARE managed-care programs are in operation, the review points for mental health services may be different.

Remember:

The sessions cannot simply be counseling sessions, such as for people who are having marital or family disagreements. They must be for treatment of a mental disorder that has a medical diagnosis.

Inpatient care, which needs advance authorization by a TRICARE contractor, is limited to a certain number of days per year unless TRICARE grants a waiver. The limits don't apply to services provided under the Program for Persons with Disabilities.

Note:

TRICARE Standard has expanded its coverage of "partial hospitalization" beyond alcoholism or other substance use disorder rehabilitation to include other mental health disorders. Partial hospitalization is when a patient checks into a health care facility on a given day for treatment, but goes home at night.

The expanded benefit is effective for care received from TRICARE Standard-authorized partial hospitalization programs, and is limited to 60 days of treatment per fiscal year, with waivers for unusual cases.

The annual limits for inpatient mental health care covered by TRICARE Standard are as follows: (1) 30 days for patients aged 19 or older; (2) 45 days for patients under age 19; (3) 150 days for inpatient care in residential treatment centers.

Remember:

Advance approval by the contractor is also required for mental health care.

Providers of care in some parts of the country, primarily the Northeast, may request waivers of the limits by calling Health Management Strategies International, Inc., the current TRICARE Standard mental health contractor, at 1-800-242-6764. In other areas, where the TRICARE program is in operation, a different mental health contractor may have jurisdiction. Check with the nearest Health Benefits Adviser/TRICARE Service Center for more information.

Before getting mental health care, be sure to check with your HBA/TSC because ***prior approval*** may be required. Also, certain reviews and paperwork must be completed at various points during mental health care for TRICARE Standard to share the bills. (See the section in this chapter titled “Some Care Needs Special Authorization” for details about required advance approval for mental health care.)

Obesity Treatment

TRICARE Standard coverage is limited to three types of surgical treatment: gastric bypass, gastric stapling and gastroplasty, including "vertical banded" gastroplasty, when one of the following conditions is met:

- A patient is 100 pounds or more over the ideal weight for height and body structure and has a life-threatening medical condition related to morbid obesity;
- A patient is 200 percent or more of the ideal weight for height and body structure, even without a related life-threatening medical condition;
- A patient has complications from a non-covered surgical treatment for obesity, such as intestinal bypass, and needs one of the three surgical procedures that are covered.

TRICARE Standard does not cover any other services or supplies related to obesity or weight reduction. And non-surgical treatment of morbid obesity, such as wiring the jaws or special diets, is not covered.

Organ Transplants

TRICARE Standard covers the following organ transplants: cornea, kidney, liver, liver-kidney, heart, lung, heart-lung, and some bone marrow. But there are limits in some circumstances. For example, bone marrow transplants are not covered for treatment of ovarian cancer. Contact your HBA/TSC or contractor ahead of time for details on organ transplants. Some organ transplants may only be provided in facilities that are authorized specifically for the particular type of transplant.

Some organ transplants may also require advance authorization. Check with your HBA/TSC.

Plastic or Reconstructive Surgery

TRICARE Standard covers plastic, cosmetic and reconstructive surgery only in the following situations:

- Plastic surgery can be cost-shared when it is needed to restore function. For example, plastic surgery on a patient's nose would be covered if it was necessary for the patient to breathe. It would not be covered just to improve the person's looks. Because this can be a gray area, check with your HBA or the regional TRICARE contractor if you have questions, before getting care;
- Plastic surgery can be cost-shared for the following reasons:
  - To correct a serious birth defect, such as a cleft lip;
  - To restore body form after an accidental injury;
  - To improve appearance after severe disfiguration or extensive scarring from surgery for cancer;
- Breast reconstructive surgery after a mastectomy is covered by TRICARE Standard regardless of when the mastectomy was performed;
- Breast construction by surgery is covered by TRICARE Standard. Along with the claims for constructive breast surgery, documentation must be submitted showing that the condition had existed since birth or was caused by an accident. TRICARE won't share the cost of reconstructive

surgery for a breast that is simply incomplete or underdeveloped;

- Breast reduction surgery may be covered under limited circumstances, for documented, intractable pain that doesn't respond to other treatments. Check with your HBA for details.

Prescription Drugs

Claims for prescription drugs can be submitted on the CHAMPUS claim form (DD Form 2642). The old form, the DD Form 2520, may still be used overseas.

You need special billing information for filing a claim for prescription drugs. (See the "Fully Itemized Bills" section in the chapter titled "How to File a Claim" for details.)

Private Duty or Visiting Nurses

There are certain limits on TRICARE Standard coverage for private duty nursing, whether in the hospital or at home.

TRICARE Standard does not cover private duty nursing to augment the general nursing staff of a hospital, or in hospitals that have intensive-care units or coronary-care units.

TRICARE Standard does cover "skilled nursing care" at home. That is, medical care that only a professional can provide, such as giving certain medications or therapy, can be cost-shared. Because this can be quite complicated, check with your HBA/TSC before you hire a visiting nurse.

Whether the private duty nurse sees you in the hospital or at home, a copy of all daily nursing notes must go in with your claim. The claim should also show the name of the doctor who referred you for private nursing and that he/she is supervising the care. A copy of the physician's treatment plan must be included with the first TRICARE Standard claim you send in.

Residential Treatment Centers (RTCs)

These are centers which provide treatment for children and adolescents (up to age 21) who require mental health care. Patients must be suffering from a serious mental disorder; children who have only disciplinary problems don't qualify. The medical necessity of a patient's admission to an RTC must be certified prior to admission by a TRICARE Standard mental health review contractor. In part of the country (mainly the Northeast), the contractor is Health Management Strategies International, Inc. (HMSI). Other contractors perform this function in areas where TRICARE managed-care support programs are in operation. Contact the appropriate TRICARE mental health review contractor for information. (See the section in this chapter called "Some Care Needs Special Authorization" for more information.) There are strict requirements for the RTCs to meet and 150-days-per-year limitations for this treatment. Before admitting your child, check with your local Health Benefits Adviser, your regional TRICARE contractor, or with the RTC itself, to make sure the facility is TRICARE Standard-authorized. RTC care is not considered emergency care and requires prior certification by HMSI.

Same Day (or "Ambulatory") Surgery

Certain surgery, like having your tonsils taken out, can often be done in ambulatory surgery centers, hospitals or special centers where you can have the operation and go home the same day. This can cost less than inpatient care. For active-duty and NATO families, it costs only $25 for the hospital's or surgery center's care, as long as the doctor participates in TRICARE Standard. Others pay only the lesser of 25 percent of an applicable group rate payment, or 25 percent of the billed charges, plus the annual deductible, as long as the doctor participates in TRICARE Standard. If the provider doesn't participate, you may have to pay up to 15 percent over the TRICARE Standard allowable charge, plus your cost-share and deductible, if any. (See an explanation in the "Outpatient Costs" section of the chapter titled "How Much Will It Cost?")

Wigs for Radiation/Chemotherapy Treatment Patients

When loss of hair is from cancer treatment, TRICARE Standard cost-shares one wig or hairpiece during a person's lifetime. Depending on whether your sponsor is an active-duty service member or not, you pay either 20 or 25 percent of the allowable charge for your wig/hairpiece. The maximum TRICARE Standard allowable charge is $750. A doctor's note saying you need the wig must be sent in with your claim. And TRICARE Standard can't cost-share a wig if you've already obtained one through the Department of Veterans Affairs (formerly known as the Veterans Administration) or a uniformed service hospital.

Some Care Needs "Special Authorization"

How to Get Approval for Care under the Program for Persons with Disabilities or for Mental Health Care

For care under the **Program for Persons with Disabilities,** available to active-duty family members only, contact your TRICARE contractor for instructions at least 30 days before you plan to get the needed care. (See the chapter titled "Program for Persons with Disabilities" for more details.)

Use DD Form 2532 or 2533 when you request approval for care under the Program for Persons with Disabilities from your TRICARE contractor. You can get the form from your HBA or your claims processor. Your doctor must send a letter to the contractor with the form explaining why you need the care.

Mental Health Care

You'll need certification of the medical necessity for mental health care from a TRICARE contractor in the following circumstances:

1. Inpatient mental health care;
2. Care at residential treatment centers;
3. All requests for extensions to TRICARE's yearly limits on inpatient mental health care;
4. Authorizations for extended outpatient mental health care, exceeding two outpatient visits per week, five inpatient visits per week, or 23 outpatient visits in a fiscal year.

The mental health contractor for parts of the country where TRICARE hasn't yet been placed into operation is Health Management Strategies International, Inc. (HMSI). Write to HMSI, CHAMP-MH Program Division, 1725 Duke St., Suite 300, Alexandria, VA 22314. Telephone toll-free: 1-800-242-6764.

Most areas of the U.S., where the TRICARE managed-care program has been implemented, will have different contractors handling mental health care advance approval. For more information, contact your Health Benefits Adviser, TRICARE Service Center, or HMSI. Always request certification from the appropriate contractor ***before*** you start getting the care, if possible. That way, you and your provider of care will know in advance whether the planned treatment meets the TRICARE rules for medical necessity and appropriateness. The TRICARE contractor will not pay a claim until the mental health contractor's certification has been given. Remember, either your HBA or HMSI can tell you who you need to contact to get approval for mental health care.

Remember:

Only those cases that meet the special and limited requirements for a waiver will receive approval for care beyond the annual limits of inpatient mental health days. And, authorization for the maximum number of days of mental health care in a year is not automatic. The care—and all other mental health care—must still meet the test of medical necessity. It may be that ***fewer*** *days of such care will be paid if it is determined by the appropriate TRICARE contractor that the additional care is not medically necessary.*

How to Get Approval for Dental Care

To get approval for dental care related to a covered medical problem in an area where TRICARE is not yet operating, send a filled-out claim form (DD Form 2642) along with a statement from the physician about the condition, and a statement from the dentist saying why you need the care, what care you need, and how much it will cost to:

Palmetto Government Benefits Administrators
P.O. Box 100599
Florence, SC 29501-0599
Telephone: (803) 665-2320

Claims for this type of dental care in regions where TRICARE is operating may be approved by different contractors. If you live, or receive covered dental care, in one of these locations, you must send the dental claim to the contractor for that area. Check with your HBA or local TRICARE Service Center for the correct mailing address.

Reminder:

The TRICARE dental coverage discussed here is completely separate from the TRICARE Active-Duty Family Member Dental Plan. (See the appropriately named chapter toward the back of the book for information on the TRICARE Active-Duty Family Member Dental Plan.)

Approval for Organ Transplants

For some organ transplants, you must get advance approval, and you must have the transplant done at a facility that is

specifically approved by TRICARE Standard for this procedure. Check with your HBA/TSC for details.

Remember:

You must get the contractor's advance approval before TRICARE Standard will pay for the above care. Also, you must be enrolled in DEERS. (See the "DEERS" section at the end of the chapter titled "Who's Covered?")

What's *Not* Covered?

This section lists most of what TRICARE does not cover. To be on the safe side, check with your HBA or TSC before getting care if you have any questions.

- **Abortions**, except when the mother's life is in danger. The attending physician must certify in writing that the abortion was performed because a life-endangering condition existed, and must provide medical documentation to the TRICARE claims processor in order for TRICARE Standard to share the cost of the procedure.
- **Acupuncture**
- **Artificial insemination**, or any forms of artificial conception. This non-coverage includes in vitro fertilization and gamete intrafallopian transfer, as well as all other non-coital reproductive methods and all services, supplies and drugs related to them.
- **Autopsy services or post mortem examination**
- **Birth control** for which you do not need a doctor's prescription. TRICARE Standard will, however, cost-share some kinds of birth control. (See the "Family Planning" section in the chapter titled "What's Covered?" and check with your HBA.)

- **Bone marrow transplants for treatment of ovarian cancer**. (See the section titled "Cancer Test Project Expansion" in the "What's Covered?" chapter.)
- **Camps** such as camps for diabetics or obese people.
- **Care or supplies** furnished or prescribed by a person in the immediate family.
- **Chiropractors and naturopaths**
- **Christian Science "absent treatment,"** also called "treatment through prayer and spiritual means," in which the patient is not physically present when the Christian Science service is rendered.
- **Chronic fatigue syndrome**: TRICARE Standard doesn't cover treatment for chronic fatigue syndrome (CFS) as a defined illness, since there are no generally accepted standards for treatment of CFS, and existing treatments have not been consistently shown to be effective. Legitimate treatment for CFS is limited to relieving individual symptoms, such as prescribing medications for headaches or muscle pains.
- **Cosmetic, plastic or reconstructive surgery**, except as described in the "Plastic or Reconstructive Surgery" section of the "What's Covered?" chapter.
- **Counseling services**: TRICARE Standard doesn't cover nutritional counseling, diabetic self-help counseling, diabetic self-education programs, stress management, life-style modifications, marriage counseling (marriage counseling isn't the same as treatment by a marriage and family therapist, which ***is*** covered under TRICARE

Standard), etc. Counseling services may be covered under the expanded preventive care benefit, as long as they are performed in connection with immunizations, pap smears, mammograms, or examinations for colon and prostate cancer. However, they are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.

- **Custodial care** in an institution or home. Custodial care is taking care of someone's daily needs, such as eating, dressing or a place to sleep, as opposed to someone's medical needs. Some aspects of the care may be covered, such as limited specific skilled nursing services (one hour per day), prescription medicines and up to 12 physician visits per calendar year. Medically necessary care for an inpatient in a hospital is covered, even if the person's condition is considered "custodial." This can be a gray area, so check with your HBA or TSC if you have questions.
- **Dental care and dental x-rays**, except as provided in the "Dental Care" section of the "What's Covered" chapter.
- **Education or training**, except under the Program for Persons With Disabilities.
- **Electrolysis**
- **Experimental procedures**
- **Eyeglasses and contact lenses**, except under very limited circumstances, such as corneal lens removal.
- **Food, food substitutes or supplements, or vitamins outside of a hospital**, except for home parenteral nutrition therapy, such as prescribed for cancer patients.

- **Foot care**, except when there's a medical problem or injury.
- **Genetic tests** not ordered by a doctor and under certain other conditions. (See the "Having a Baby" section of the "What's Covered?" chapter and check with your HBA or TSC.)
- **Hearing aids**, except under the Program for Persons with Disabilities. (See the chapter titled "Program for Persons with Disabilities.")
- **Hearing examinations**, unless in connection with surgery or some medical problem, or under the Program for Persons with Disabilities. But there are hearing examinations under the well-child care benefit.
- **Immunizations for children aged 6 and older**, unless in connection with health promotion and disease prevention visits to the doctor, or diagnostic or preventive pap smears and mammograms.
- **Learning disabilities**, such as dyslexia.
- **Megavitamins and orthomolecular psychiatric therapy**
- **Mind expansion or elective psychotherapy** (for example, Erhard Seminar Training (EST), transcendental meditation and Z-therapy).
- **Orthodontia**, except in limited cases, such as when related to the surgical correction of a cleft palate.
- **Orthopedic shoes and arch supports**, except when part of a brace.

- **Over-the-counter drugs**—those not requiring a prescription by a physician. TRICARE Standard does not share the cost of drugs available without a prescription, even if a physician does write a prescription for such drugs.
- **Private hospital rooms**, unless the doctor orders it for medical reasons, or a semi-private room is not available. Hospitals that are subject to TRICARE's diagnosis-related groups (DRG) payment system may provide the patient with a private room, but will still only receive the standard DRG amount. If a patient asks for a private room, the hospital can bill the patient for the extra charges.
- **Rest cure**
- **Retirement homes**
- **Self-help courses, relaxation**: TRICARE Standard doesn't cover self-help courses, items or charges related to exercising or relaxation, such as spas, whirlpools, hot tubs, swimming pools, and the like.
- **Sex changes**
- **Speech therapy**, except when related to a specific illness or injury.
- **Sexual inadequacy treatment**
- **Surgical sterilization reversals**
- **Telephone services or advice** (except in TRICARE regions), including remote monitoring and consultation, except for trans-telephonic monitoring of pacemakers. Other types of diagnoses or monitoring by telephone may be available. Check with your HBA or TSC for details.

- **Weight control** or weight reduction services and supplies are not covered, except for certain surgical procedures when specific conditions have been met. (See "Obesity Treatment" in the "What's Covered?" chapter for details.)
- **Workers' compensation**: TRICARE Standard will not cost-share work-related illnesses or injuries that are covered under workers' compensation programs.

Medical Review

Regional medical review organizations are under contract to TRICARE to review some types of care received by eligible patients before TRICARE shares the cost of that care. The care that's reviewed includes inpatient care which falls under TRICARE's diagnosis-related groups (DRG) payment system. Outpatient care may also be evaluated. The review organizations make sure the care is reasonable, necessary and appropriate.

Physicians and hospitals are generally familiar with, and are required to participate in, a TRICARE contractor's medical review program.

If you have any questions about whether medical review applies to the care you may receive, check with your physician or hospital.

Special rules apply in situations where review organizations evaluate care. Requests for reconsideration of review decisions should be submitted directly to the review organization, following the appeal instructions contained in the initial determination letter to you.

In areas where the full TRICARE program is in operation, the TRICARE contractors handle reviews of medical care.

Where to Get Care

Try to Use a Service Hospital to Save Money

Always try to get your health care from a uniformed service hospital or clinic first. If you live in certain ZIP codes around a service hospital, you must try to get inpatient care from that hospital first, except in a true medical emergency, or when you have other, non-TRICARE Standard, major medical insurance.

Using a military hospital instead of TRICARE Standard saves you money and paperwork. So, check with your HBA to find out if the hospital can care for you.

Even if you live far away from a military hospital, it can still cost you less to get care there. This is especially true for major procedures that cost a lot. The transportation to and from the military hospital could cost you much less than your cost-share under TRICARE Standard. And in some cases, the uniformed services may be able to assist with transportation. Check with your HBA or TRICARE Service Center (TSC).

Who Has Priority for Care at Service Hospitals?

Call ahead to the military hospital to see if you can be treated there. Patient priorities in these hospitals changed in August 1996, so that persons who are enrolled in

TRICARE Prime will be seen first. While you may be eligible for care, there may not be space available.

Here's the order of priority for health care in military medical facilities, as established by the Assistant Secretary of Defense for Health Affairs:

1. **Active-duty service members;**
2. **Active-duty family members *who are enrolled in TRICARE Prime* (for the purpose of determining access priority, survivors of military sponsors who died on active duty *who are enrolled in TRICARE Prime* are included in this priority group);**
3. **Retirees, their family members and survivors *who are enrolled in TRICARE Prime;***
4. **Family members of active-duty service members *who are NOT enrolled in TRICARE Prime* (for the purpose of determining access priority, survivors of military sponsors who died on active duty, who are *not* enrolled in TRICARE Prime, are included in this priority group);**
5. **All other eligible persons.**

As of mid-1997, you can still get outpatient care from a military hospital free. And for inpatient care, you pay only a small amount for each day. This daily fee is usually much less than the daily costs in a civilian hospital. Furthermore, you don't need a nonavailability statement for care at a military hospital and you don't have to file any claims.

If You Live Near a Uniformed Service Hospital, You Must Try It First

If you live in certain ZIP codes around a military hospital, you must try to use that hospital for nonemergency inpatient care. Otherwise, TRICARE Standard cannot help pay for any of the care if you get it from civilian sources instead.

The ZIP code zones are specific for each military hospital and are updated periodically. Check with your HBA or TSC if you aren't sure whether your home address falls within the ZIP code zone. (***Note***: Outside the 50 states and Puerto Rico, a 40-mile radius around a hospital is used—not ZIP code zones.)

Important:

For some kinds of highly specialized care such as open-heart surgery, the ZIP code service areas are being expanded to zones of up to 200 miles around particular military hospitals, or perhaps even nationwide in extraordinary cases, such as for certain organ transplants. This means that if you need a certain type of specialized care, you may have to try to get the care at a specific military medical facility that may be a considerable distance from your home. This new requirement makes it even more important that you check with your nearest HBA or TSC before seeking care from a civilian source under TRICARE Standard.

Nonavailability Statements

If the military hospital near you cannot provide the inpatient care you need, ask them for a nonavailability statement.

A nonavailability statement (NAS) is a certification from a military hospital stating that it cannot provide the care. If you don't get a nonavailability statement before you get inpatient care from a civilian source, TRICARE Standard may not share your costs.

The NAS system is now automated. This means that, instead of paper copies of the NASs being sent in with the TRICARE Standard claim, the uniformed service medical facility enters the NASs *electronically* into the DEERS computer files. These electronically filed NASs are the only ones accepted for processing TRICARE Standard claims.

Several years ago, the need for NASs was expanded to certain outpatient medical procedures. The requirement for NASs for these outpatient procedures was removed in late 1996, for services received on or after Sept. 23, 1996. But for any of these outpatient services received *before* Sept. 23, 1996, an NAS is still required. The outpatient services are:

- Gynecological laparoscopy—use of an instrument called a laparoscope to examine female reproductive organs in the abdomen;
- Cataract removal;
- GI endoscopy—visual examination of the interior of the gastrointestinal tract;
- Myringotomy or tympanostomy—incision of the tympanic membrane in the ear to relieve pressure and drain fluid from the middle ear. This includes placement of tubes in the ear to aid drainage;

- Arthroscopy—use of an instrument to visually examine the interior of a joint, such as the shoulder, elbow, wrist, knee, and ankle;
- Dilation and curettage (D&C)—widening of the cervical canal and scraping of the uterine cavity for diagnostic or therapeutic reasons;
- Tonsillectomy or adenoidectomy;
- Cystoscopy—use of an instrument to examine the interior of the bladder;
- Hernia repairs;
- Nose repair—rhinoplasty and septoplasty (changing the shape of the nose);
- Ligation or transection of fallopian tubes—cutting the fallopian tubes to prevent fertilization;
- Strabismus repair—surgery to lengthen or shorten muscles that help the eyes function together;
- Breast mass or tumor removal;
- Neuroplasty—decompression or freeing of nerves from scar tissue.

Important Note:

*Even though NASs are no longer required for the outpatient procedures listed above, there is a requirement (**only** in areas where TRICARE is in full opera-*

tion—which should include the entire country by mid-1998) *that* ***all*** *TRICARE-eligible persons—not just those who live within the ZIP code service area of a uniformed services hospital—****must have the procedures listed above, plus three others, approved ahead of time by the regional TRICARE contractor****. The three additional procedures also on the list of those needing advance authorization by the TRICARE contractor are: (1)* ***cardiac catheterization****; (2)* ***laparoscopic cholecystectomy*** *(gall bladder removal); and (3)* ***magnetic resonance imaging*** *(MRI). Check with your TRICARE contractor, or with your nearest TRICARE Service Center (TSC), for details on getting advance authorization to have any of these procedures done—and to find out if your TRICARE contractor has included any* ***other*** *procedures in the list of those needing prior approval. Providers of care—whether or not they participate in TRICARE Standard—are supposed to get these advance authorizations. If they don't (or won't), you should check with the Health Care Finder (HCF) at your nearest TSC to ensure that the procedure will be covered.*

If you live in the ZIP code zone around a military hospital, the only times you ***don't*** need a nonavailability statement for non-emergency inpatient care are:

- **When you have other non-TRICARE Standard major medical care insurance** that pays first on the bills for TRICARE Standard-covered care. (Check with your HBA, TSC or TRICARE contractor on this.)
- **In a true medical emergency**. A medical emergency is the sudden and unexpected onset of a medical condition, or the

acute worsening of a chronic condition, that is threatening to life, limb or sight, and which requires immediate medical treatment, or which requires treatment to relieve suffering from painful symptoms. Medical emergencies include heart attacks, cardiovascular accidents, poisoning, convulsions, kidney stones, and other acute conditions that are determined to be medical emergencies. Pregnancy-related medical emergencies must involve a sudden and unexpected medical complication that puts the mother, the baby, or both, at risk.

Be sure to check with your nearby military hospital or clinic *every time* you need inpatient care. Even if they couldn't provide the care you needed the last time you checked, their staffing levels or capabilities may have changed, and they may now be able to care for you.

Remember:

An NAS is valid for a hospital admission which occurs within 30 calendar days after the NAS is issued. It will remain valid from the date of admission until 15 days after discharge for any follow-up treatment that's directly related to the admission.

For ***maternity care***, the date of admission is considered to be the date when the patient entered into the prenatal care program with a civilian provider of care. The maternity NAS will remain valid until 42 days following termination of the pregnancy.

For ***newborn care***, in the event that a newborn infant stays in the hospital continuously after the mother's discharge, the mother's NAS will remain valid for the infant in the same hospital for up to 15 days after the mother's discharge. Beyond this

15-day limit, a claim for non-emergency inpatient care requires a valid NAS in the infant's name.

Remember:

Just because a uniformed service hospital gives you a nonavailability statement does not mean that TRICARE Standard can help you pay for all care that you receive from any provider. TRICARE Standard cost-shares only the kinds of care allowed by the TRICARE Standard rules. And TRICARE Standard helps pay for care only from the kinds of providers TRICARE Standard recognizes. These providers are listed below.

Where and From Whom Can You Get Care under TRICARE Standard?

A "provider" is the person, business or institution that provides or gives you health care. For example, a doctor is a provider. A hospital is a provider. An ambulance company is a provider. There are many other types.

TRICARE Standard can help pay for covered services only from the types of providers listed on the next pages.

In addition to being on the list below, providers must be approved or authorized (certified) by TRICARE. That usually means the providers are licensed by their state, are accredited by a national organization and/or meet other standards of the medical community, and have a complete certification package on file with the appropriate TRICARE contractor. If a provider is not authorized, TRICARE Standard cannot help pay for care from that provider. Most hospitals and doctors are authorized by TRICARE (check with them, just to be certain). But for

other types of providers, it's a good idea to check with your regional contractor, TSC or HBA before getting care to make sure they're authorized by TRICARE.

Generally, active-duty service members and civilian employees of the federal government are not authorized to be providers of care under TRICARE. So, TRICARE-eligible persons should be careful about seeking treatment from the "outside" practices of federal government medical personnel.

Health Care Centers

- **Hospitals**
- **Christian Science sanatoria**, if part of the First Church of Christ, Scientist.
- **College or university infirmaries**
- **Skilled nursing facilities**, not including retirement homes or homes for the aged or infirmed, which are not covered by TRICARE.
- **TRICARE-approved residential treatment centers** for emotionally disturbed children and adolescents.
- **TRICARE-approved special treatment centers**, such as drug and alcohol treatment centers.
- **TRICARE-approved ambulatory surgery centers**
- **TRICARE-approved birthing centers**. Separate approval is required for care at a birthing center, even if the center is otherwise authorized as a provider of care by TRICARE. Check with your HBA or TSC.

Note:

Check with your HBA or TSC before getting care at certain facilities, such as outpatient rehabilitation facilities, birthing centers, pain treatment facilities, mental health clinics, residential treatment centers, and eating disorder clinics. They may not be TRICARE-authorized providers of care, or the services they provide may not be benefits under TRICARE Standard.

Individual Providers

- **Physicians**, including both doctors of medicine (M.D.s) and doctors of osteopathy (D.O.s).
- **Attending physicians**. Another provider of care (podiatrist, clinical psychologist, oral surgeon, etc.) may be treated as an attending physician, as long as he or she is operating within the confines of the scope of practice of that particular discipline. TRICARE's definition of "surgical assistant" has also been expanded to include other authorized individual professional providers. This will allow dentists or podiatrists to assist when the surgery is complex enough to warrant an assistant.
- **Dentists** (D.D.S.s or D.M.D.s)
- **Most clinical psychologists** with Ph.D.s or Psy.D.s
- **Podiatrists** (D.P.M.s)
- **Physician assistants** (P.A.s). Physician assistants must meet applicable certification and licensing criteria, and must be supervised by physicians who employ them and

who are themselves authorized providers of care under TRICARE.

- **Certified nurse midwives**
- **Christian Science practitioners** and nurses, if currently listed in the *Christian Science Journal*.
- **Certified clinical social workers** with at least a master's degree in social work from an accredited school of social work, plus two years of post-graduate clinical experience.
- **Certified nurse practitioners** and clinical nurse specialists, if approved by the state in which they work.
- **Certified psychiatric nurse specialists**
- **Certified marriage and family therapists**. Certified marriage and family therapists may be authorized as independent providers of care (that is, they don't require physician referral and supervision) under TRICARE, but only when they sign an agreement with TRICARE. The agreement requires certified marriage and family therapists to accept the TRICARE Standard allowable charge as the full fee for their services (they can't bill the patient separately for charges disallowed by TRICARE Standard or for non-covered services they provide). Therapists who don't sign the agreement may not be authorized by TRICARE as certified marriage and family therapists.

  Remember:

  TRICARE Standard won't pay for marriage and family counseling, but will share the cost of psychotherapy provided by certified marriage and family therapists in the treatment of a valid mental disorder.

- **Optometrists** (O.D.s)

Your doctor may also refer you to someone else for certain services. TRICARE Standard cost-shares covered services from the providers below only if the referring doctor's name is shown on the claim form:

- **Independent laboratories**
- **Radiology services**
- **Pharmacies**
- **Ambulance companies**
- **Medical equipment and supply firms**

As long as a physician refers you and supervises the care, and other requirements are met, covered services from the providers below can be cost-shared. The name of the physician who referred you and is monitoring the care must be indicated on the claim form:

- **Registered nurses** (R.N.s)
- **Licensed practical nurses** (L.P.N.s)
- **Physical therapists** (P.T.s)
- **Occupational therapists** (O.T.s)
- **Mental health counselors**
- **Audiologists**
- **Speech therapists**
- **Pastoral counselors**

Providers Who Participate in TRICARE Standard Save You Money

Providers who "participate in TRICARE Standard" agree to accept the TRICARE Standard "allowable charge" as their full fee for your care. (***Note***: "Accepting assignment" means the same as participating.) The allowable charges for medical services are based on computations made under a method called the "resource-based relative value system" (RBRVS). Your cost-share is based on the allowable charge—no matter what the provider actually bills you. So with providers who participate in TRICARE Standard (and after your annual deductible has been accounted for), you only pay your cost-share for TRICARE Standard-covered care and charges for any care not covered by TRICARE Standard. (The provider may ask you to pay your cost-share right away or may wait until after TRICARE Standard has paid the claim.)

Providers who do not participate will bill you for their normal charges. The law says that bill may be up to 15 percent more than the TRICARE Standard allowable charge. You arrange with the provider how you will pay the bill. When you or the provider files the TRICARE Standard claim, TRICARE Standard pays you its share of the allowable charge. That means you pay your cost-share, and you pay any difference between the allowable charge and the actual bill, up to the legal billing limit. (See the chapter on costs for more information.)

How to Find Providers Who Participate in TRICARE Standard

Individual professional providers of care who have not signed up to be part of a TRICARE Prime or Extra network

participate voluntarily in TRICARE Standard. And, they can choose to participate on a case-by-case basis. That is, they may participate one time and not the next time. Your nearest HBA or Health Care Finder, your contractor or your friends and neighbors who have used TRICARE Standard may be able to tell you of providers who have participated in TRICARE Standard in the past.

Before getting care, call and ask if the provider will participate in TRICARE Standard. Be sure they understand that by "participating in TRICARE Standard," they are agreeing to accept the TRICARE Standard allowable charge as their ***full*** fee for your care. If the provider isn't familiar with TRICARE or has any questions, tell the provider to call the toll-free phone number of the regional TRICARE contractor. Some contractors have a separate, special phone line for providers. Or the provider can ask to be contacted by the contractor's field representative. He or she can tell the provider the allowable charges for the type of care you need. If the provider doesn't know the contractor's phone number, he or she should check with the nearest HBA or TRICARE Service Center.

Note:

By law, providers may not discriminate against you because of race, color, national origin, religion, sex, handicap or age. If you believe you've been discriminated against, contact your HBA or TSC, or write to the TRICARE Support Office, Aurora, CO 80045-6900.

Also Important:

All hospitals that participate in Medicare, and hospital-based health care professionals who are employed by, or contracted to, such hospitals, are required by law to

participate in TRICARE Standard for inpatient hospital services related to hospital admissions. But remember that some individual providers of care who see patients in the hospital may not participate and may bill separately for their services.

Note For Overseas Travelers:

If you need medical care while traveling in a country where there's no U.S. military medical facility, contact the nearest U.S. consular office for their recommendations on nearby providers of care. If you're unable to do that, try to identify such providers through local sources such as hospitals or clinics.

If you do happen to be traveling in a country where there's a U.S. military medical facility, try to get care there. If that's not feasible, the facility's Health Benefits Adviser might be able to direct you to the type of health care provider you need.

If you plan to do any traveling outside the U.S., claims for any care you receive should be sent as follows:

1. *If you live in an area where TRICARE is in full operation,* your claims for care received outside the country will go to the TRICARE contractor for the *area in which you live*.

2. *If you live in one of the remaining areas where TRICARE hasn't yet been implemented,* your claims for overseas care should be mailed to the contractor for the *area in which you received care*.

Refer to the "How to File a Claim" chapter of this handbook for information on where to file claims. Be sure to send

your claims to the claims processor who's responsible for handling claims from the country where you received care.

Care for Active-Duty Families and Others in Overseas Areas

Military force reductions in Western Europe and elsewhere have resulted in reduced levels of medical services for many areas, particularly those where the numbers of active-duty forces no longer are enough to support a military health clinic. Service members and their families, especially those in remote areas, have sometimes had problems getting care.

As part of its TRICARE managed-care health program for military families, the Defense Department has established the TRICARE Overseas Program (TOP). TOP blends many of the features of Defense's stateside TRICARE program, while also allowing for the cultural differences and differing health care practices in other countries. TOP consists of three regions: TRICARE Europe, TRICARE Pacific, and TRICARE Latin America. TOP covers all geographic areas and territorial waters outside the continental U.S., except for Puerto Rico.

In order to ease the overseas active-duty family's path to health care, the government has taken several steps:

1. All cost-shares and deductibles are waived for Prime-enrolled active-duty families in overseas areas.

2. Prime-enrolled active-duty family members who can't get care in overseas U.S. military medical facilities will be able to see TRICARE-authorized local host-nation civilian providers of care at no cost, when referred by the Primary Care Manager (PCM) and authorized by the

military regional service center. Persons who aren't enrolled in TRICARE Prime will use TRICARE Standard.

3. Where possible, military regional service centers in overseas areas will have written agreements with local host-nation civilian providers.

Points of contact have been established throughout overseas areas to assist families and providers with claims filing and payment issues. (See the first chapter in this book, "A Look at TRICARE," for information on how TRICARE works in overseas areas for active-duty families and other eligible persons.)

New Choices in Health Care for Military Families

Remember that the changing face of health care for service families in the 1990s means that you have (or soon will have) new choices concerning where, and how, to use your uniformed service health care benefits.

As we noted at the beginning of this book, the military health care system is still evolving, and you're likely to encounter more refinements in it over the next several years. Meanwhile, in today's (mid-1997) military health care environment, the three-option TRICARE managed-care program is becoming available to military families nationwide. (See the section in the front of this book on TRICARE Prime and TRICARE Extra for more details about the TRICARE health care options.)

As noted earlier in this book, TRICARE offers the following choices:

1. You may use standard CHAMPUS, which is becoming known as TRICARE Standard as the TRICARE program takes hold around the country and overseas, and which is the program described in this section of the handbook.

2. You may use TRICARE Extra, which features providers of care who are part of an organized network (often known as a "preferred provider organization," or PPO), and who have agreed to participate in TRICARE for all eligible patients. They'll accept the TRICARE allowable charge (or a negotiated fee) as the full fee for the care they provide and will file claims for you. Your share of the cost of care will be reduced; for example, an active-duty family's normal 20 percent cost-share under TRICARE Standard is reduced to 15 percent under TRICARE Extra. You don't have to enroll, and you may jump back and forth between this option and TRICARE Standard as you desire.

3. You may enroll in TRICARE Prime, which is a health maintenance organization-type (HMO) option. Under this plan, which is currently the least-costly health care option, you must get all of your care from the providers of care in the organization, for as long as you're enrolled. Your care is managed through a Primary Care Manager (PCM) whom you select or to whom you are assigned. Your PCM initiates, and the Health Care Finder (HCF) authorizes, all specialty referrals according to TRICARE contractor policies. There are no deductibles or cost-shares; instead, you may pay an annual enrollment fee, and small pre-set fees (also called co-payments) whenever you visit a clinic, see the

doctor, or get a prescription. There are additional health care benefits, such as preventive medicine services, that aren't covered under TRICARE Standard. And, there are no claims to file.

Managed-care programs are also available to service families at Uniformed Services Treatment Facility (USTF) hospitals that were formerly U.S. Public Health Service hospitals. The USTF hospitals and clinics where you can enroll in the managed-care options are:

- Bayley Seton Hospital, Staten Island, N.Y.
- Johns Hopkins Medical Services Corp., Wyman Park Medical Center, Baltimore.
- Brighton Marine Public Health Center, Boston.
- Martin's Point Health Care Center, Portland, Maine.
- Lutheran Medical Center, Cleveland.
- Pacific Medical Center and Clinics, Seattle.
- Sisters of Charity of the Incarnate Word Health Care System—both in Texas (Port Arthur and Houston).

When TRICARE begins operating in the regions where these USTF hospitals are located, they will no longer be considered equivalent to military medical facilities, but will become what's called "designated providers" (for the USTF hospitals in Texas and Washington State, where TRICARE is already operational, this change in designation will occur on Oct. 1, 1997). They will offer the TRICARE Prime benefit, and will serve as primary care managers for some Prime enrollees. Persons who are enrolled in the managed-care programs that

have been offered by the USTF hospitals and who are 65 years of age or older—or who will become 65 soon—may keep their enrollments after TRICARE comes to their region. No *new* "over-65" enrollments will be accepted—but as people who are over 65 leave the managed-care programs at the hospitals, other persons who are age 65 or older may be allowed to enroll to replace them, up to the limits of current enrollment levels for persons over 65.

Note:

If you enroll in TRICARE Prime and later move away from that contractor's managed-care area to a non-managed-care area, ***be sure to disenroll yourself and your family from the managed-care program before leaving your old place of residence.*** *If you're moving to a different managed-care area, and you wish to maintain your Prime enrollment in the new area, you may transfer enrollment when you reach your new location. Your enrollment in the old location will continue for up to 30 days while you're in transition, until you enroll with the contractor in the new area. Check with your HBA, Health Care Finder (HCF) or TRICARE Service Center (TSC) for more information.*

Also, in another expansion of government health care resource sharing, Department of Veterans Affairs (VA) Medical Centers in Asheville, N.C., Syracuse, N.Y. and Indianapolis, Ind. have become TRICARE-authorized providers of care. They provide limited outpatient and inpatient medical and surgical care to TRICARE-eligible persons who live in these areas. The hospitals have coordinators who serve as Health Benefits Advisers and Health Care Finders for TRICARE-eligible families.

How Much Will It Cost?

TRICARE Standard cost-shares only certain medical bills. You pay the full bill for any care that is not covered by TRICARE Standard.

And for care that is covered, you still pay for part of the bills. How much you pay (your "cost-share") depends on:

- Whether (and where) you get care as an outpatient or inpatient. "Outpatient care" is when you don't need to stay 24 hours or longer in a hospital or other health care center. "Inpatient care" is when you're admitted to a hospital or health care center with the reasonable expectation that you'll occupy a bed and will remain in the institution for at least 24 hours;
- Whether the provider participates in TRICARE Standard;
- Your sponsor's status with the service. Active-duty families pay a different share than retirees, their families and families of service members who have died, and eligible former military spouses. (See the exception to this at the beginning of the "Who's Covered?" chapter.)

Remember:

It's your responsibility to arrange to pay the provider your part of the bills. Sometimes the provider may want you to pay part or even all of the cost before you get care.

The Law Limits How Much You Can Be Charged

Certain health care providers who see TRICARE patients but who don't "participate"—also known as "accepting assignment"—in the program are limited by federal law in how much they can charge TRICARE patients for the services they provide.

Non-participating providers, with some exceptions, may charge no more than 15 percent above the TRICARE maximum allowable charge for their services.

Providers who do participate in TRICARE accept the TRICARE maximum allowable charge as the ***full*** fee for the care they render.

The billing restriction for non-participating providers is contained in Section 9011 of the Department of Defense Appropriations Act of 1993 (Public Law 102-396), and was effective on Nov. 1, 1993. The legal limit on charges is the same as that used by Medicare.

Providers who are exempt from the limit are: pharmacies, ambulance companies, independent laboratories, durable medical equipment and medical supply companies, and mobile x-ray companies. X-ray companies that are in a fixed location are not exempt from the billing limit.

TRICARE patients who feel that they've been overcharged by a provider of care, and who can't resolve the situation with the provider, may write a letter of complaint to the TRICARE contractor for their state. The contractor will send the provider a letter which explains the legal requirement and which asks that the provider refund any charges in excess of the limits to the patient within 30 days.

A provider who doesn't comply with the refund request may ultimately lose his or her authorization to treat TRICARE patients and to be reimbursed for it by the government. What this means to TRICARE-eligible patients is that they could still be treated by such a provider, but they would have to pay the full bill for any care they might receive; there would be no government reimbursement of any part of the cost.

Some Medical Costs Are "Capped"

Over the next few pages, we'll be talking about the costs of inpatient and outpatient care under TRICARE Standard. While you're reading this material, keep the following important points in mind. A cost "cap" has been placed on your cost-share—that is, on how much you have to pay—for TRICARE Standard-covered medical bills in each fiscal year (October 1 through the following September 30). The limit, or "cap," on cost-shares for each fiscal year is $1,000 for active-duty families and $7,500 for all other TRICARE Standard-eligible families.

The cap applies only to the amount of money required to meet your family's annual deductibles and cost-shares based on TRICARE Standard allowable charges for covered medical care received in any one fiscal year. You must pay any charges, up to the legal limit, in excess of those TRICARE determines to be reasonable, or "allowable," for covered care. You must pay all charges for treatment not covered by TRICARE, such as acupuncture, for example. Likewise, any costs you pay under the TRICARE Standard Program for Persons with Disabilities are not counted toward the cap.

Keep track of how much you pay in annual deductibles and cost-shares in a fiscal year. The best way to keep track of medical expenses that count toward meeting the cap is to keep a copy of your TRICARE Standard Explanation of Benefits (EOBs), which is provided with each claim that is processed. TRICARE contractors also keep track, and when your family's deductibles and cost-shares in a given fiscal year add up to the cap amount, TRICARE Standard will pay the full allowable charges for covered care provided during the rest of the fiscal year.

Remember:

You're still responsible for payment of charges in excess of the allowable charges, up to the legal limit, when you go to a non-participating provider.

For more details on the medical expense cost-share caps, contact your HBA or TRICARE Service Center.

Outpatient Costs

For outpatient care for most families, there is a yearly deductible of $150 for one person or $300 for a family. That is, you pay your provider(s) the first $150 (or, for a family, $300) worth of TRICARE Standard allowable medical bills in a fiscal year. The deductible for family members of active-duty E-4s and below is $50 for an individual and $100 for the entire family.

After the deductible is met, active-duty families pay 20 percent of the TRICARE Standard allowable charge for each medical bill (except for ambulatory surgery centers, free-standing birthing centers and hospital-based birthing rooms, for

which the charge is a flat $25) and all others pay 25 percent. If a health care provider who does not participate in TRICARE Standard bills you for more than the allowable charge, you also pay the additional amount, up to the legal limit of 15 percent above the TRICARE Standard allowable charge.

The allowable charge is the maximum amount TRICARE Standard will pay for care given by physicians and other providers. It's determined by comparing the actual billed charges, the prevailing charges (what most providers have been charging) for a particular service, and a charge arrived at by applying a Medicare-related formula—then using the lowest of the three as the TRICARE Standard allowable charge.

Outpatient Costs With Providers Who Participate in TRICARE Standard

A provider who participates in TRICARE Standard will send in the claim for your care to the TRICARE contractor. TRICARE Standard will send its share of your medical bills directly to the participating provider. You should arrange with the provider how and when to pay your part of the bill.

Note:

A new, simpler claim form for patients, the DD Form 2642 ("CHAMPUS Claim—Patient's Request for Medical Payment") was introduced in 1994. The new form replaced the DD Form 2520, which is no longer used in the U.S. The new form is only half the length of the old form, and doesn't require a provider's signature. Providers who send claims to TRICARE will use the HCFA Form 1500 (for individual providers) or the

UB-92 form (for institutional providers, such as hospitals).

The TRICARE contractor knows the allowable charge for the TRICARE Standard-covered care you receive. The deductible and patient cost-share are subtracted from that amount, unless you have already met the deductible for the year. The claims processor then sends your provider a check for the TRICARE Standard share of the remaining amount.

How Much is Paid?

- For families of active-duty service members, the check will be for 80 percent of the remaining allowable amount. You must pay the other 20 percent, plus the deductible if it has not already been paid, to your provider—except for care in ambulatory surgery centers and free-standing birthing centers. (See previous page.)
- For retirees, their families, families of service members who have died, and for eligible former military spouses, the check will be for 75 percent of the remaining allowable amount. You must pay your provider the other 25 percent, plus the deductible if it has not already been paid.

All families also pay the full amount for any care that is not covered by TRICARE Standard.

Here's an example of how this works. Sgt. King is an E-5. His wife, Becky, went to see Dr. Moffett because of stomach pains. Dr. Moffett normally charges $150 for the care Becky received. But Dr. Moffett said he would participate in TRICARE Standard (sometimes also called "accepting TRICARE Standard assignment"). And, he told Becky she

could pay after TRICARE Standard had paid its share of the bill.

The TRICARE contractor knew from the files that all of Becky's care was covered and the allowable charge for the care was $125. The files also showed that Becky had already paid her $150 deductible that year. Since Becky was married to an active-duty service member, the contractor sent Dr. Moffett a check for 80 percent of the allowable, or $100. The contractor also sent Becky a notice (or "Explanation of Benefits") that Dr. Moffett had received $100 and that she needed to pay Dr. Moffett the remaining $25. So her total cost for the care was $25 (20 percent of the allowable charge of $125).

Outpatient Costs With Providers Who Don't Participate in TRICARE Standard

If your provider doesn't participate in TRICARE Standard, the bill may legally be for up to 15 percent more than the TRICARE Standard allowable charge. And you must arrange payment to the provider for the entire bill, up to the legal limit.

If you're filing the claim, you fill out and sign the DD Form 2642 claim form. Ask your provider for a fully itemized bill. Then send the claim form, a copy of the bill, and a request for a waiver of the new claim filing requirement, if necessary, to your TRICARE contractor. (See the "How to File a Claim" chapter for a list of contractors.) TRICARE Standard can then pay you what it would have paid the provider, if the provider had participated in TRICARE Standard.

The contractor still uses the allowable charge to figure the TRICARE Standard cost-share for covered care—no matter

what the provider charges you. The deductible is subtracted from the TRICARE Standard allowable charge first; then the cost-share is figured based on the remaining balance, unless you have already paid your deductible for that year. The contractor then sends you a check for the TRICARE Standard portion of the remaining allowable amount.

For families of active-duty members, the check will be for 80 percent of the remaining amount, except for care in ambulatory surgery centers or in free-standing birthing centers. (See the "Outpatient Costs" section at the beginning of this chapter.)

For retirees, their families, families of service members who have died, and eligible former spouses, the check will be for 75 percent of the remaining amount. (See the exception for surviving family members at the beginning of the "Who's Covered?" chapter.)

All families also pay the full amount for any care that is not covered by TRICARE Standard.

Here's an example of how this works. Lt. Sorenson's son, Jerry, went to see Dr. Manning because of a swollen finger. Dr. Manning examined Jerry and x-rayed his finger. Dr. Manning said he would not participate in TRICARE Standard, nor would he file the claim for them. He charged Jerry's parents $225.

Dr. Manning wanted to be paid "up front," so the Sorensons paid him $225. They then filled out a DD Form 2642 claim form and sent it to their TRICARE contractor. They included Dr. Manning's fully itemized bill. Soon, Jerry's parents received a check for $160 from the contractor.

How did the contractor know to pay Jerry's parents $160? The contractor saw from the bill that all of Jerry's care was

covered by TRICARE Standard. The allowable charge for the care was $200. Since Lt. Sorenson was an active-duty member, and had already paid the family deductible, TRICARE Standard paid 80 percent of the allowable charge of $200.

Notice that in this case, the Sorensons ended up paying $65 of Dr. Manning's bill for $225. They paid 20 percent of the allowable charge plus the $25 difference between the allowable charge and Dr. Manning's bill.

Inpatient Costs

Care in a hospital is not necessarily inpatient care. Usually, if you stay in a hospital for less than 24 hours, you're an outpatient. If you are admitted to the hospital for an overnight stay (usually 24 hours or more), you're an inpatient. There is no deductible for inpatient care. But, remember, just as for outpatient care, you pay in full for any inpatient care not covered by TRICARE Standard.

Most Hospitals Participate in TRICARE Standard

When the hospital and doctors participate in TRICARE Standard, they usually fill out and send in the claims for both the hospital's and the doctors' bills. However, you must arrange with them when and how to pay your part of the bills. How much you pay depends on your sponsor's status with the service.

As mentioned earlier, all hospitals that participate in Medicare must, by law, participate in TRICARE Standard as well. But some individual providers of care who see you in the hospital are not employed by that hospital. These providers

may or may not participate in TRICARE Standard. They may bill separately, and may charge more than the TRICARE Standard allowable charge for their services.

"DRG" Hospital Payment Rules

A few years ago, TRICARE began using a system, similar to that used by Medicare, for paying civilian hospitals for inpatient care. Under the system, called "diagnosis-related groups" (DRGs), most hospitals in the 50 states, the District of Columbia and Puerto Rico are paid a fixed rate for inpatient services, regardless of how much the care costs. Maryland and New Jersey are currently exempt from the DRG payment system because of their stricter state laws.

The DRG amounts paid for inpatient services are based generally on national averages of costs for specific services. The fixed amount that TRICARE Standard pays to a hospital under the DRG system may be either more or less than the hospital charges for a given service.

Note:

Individual doctors' fees for services they provide are not paid by DRG amounts. And, some hospitals even within the so-called "DRG states" are also exempt from DRG payment limits. These hospitals are: psychiatric, cancer, long-term care, rehabilitation, and sole community hospitals exempt from Medicare''s prospective payment program. The payment system doesn't apply to certain services, such as those provided in exempt psychiatric units or hospitals, kidney-acquisition costs, heart and liver transplants, and

children's inpatient cases involving bone marrow transplants, cystic fibrosis, and children who test positive for the HIV (AIDS) virus. Additionally, Christian Science sanatoria and distinct parts of a hospital providing psychiatric or rehabilitation services would not be affected. In non-DRG hospitals, TRICARE Standard will pay as before.

Families of active-duty members pay at least $25 for each admission or a small daily fee for each day in a civilian hospital—whichever total is greater. The daily fee, which is the same charged for inpatient care at military hospitals, changes over time. But no matter how short your hospital stay, you must pay at least $25. TRICARE Standard pays the rest of your covered inpatient bills if all providers participate in TRICARE Standard. (For fiscal year 1997, the daily fee is $9.90; for civilian inpatient mental health care for active-duty families, it's $20 per day.)

Retirees, their families, the families of service members who have died, and some former spouses of service members will pay the lesser of 25 percent of the billed charges or a fixed daily amount ($360 in fiscal year 1997). TRICARE Standard will pay the rest of your covered hospital bills.

All families also pay the full amount for any care that is not covered by TRICARE Standard.

Important Note:

Under certain conditions newborns and infants won't be covered by the DRG payment system, but will have their care paid under the methods that TRICARE Standard used for all care before the DRG system went into effect. The exceptions are as follows:

- Newborns and infants who are less than 29 days old when admitted or readmitted to the hospital, unless it's for normal newborn care;
- Children who have bone marrow transplants;
- Children who have tested positive for the HIV (AIDS) virus;
- Children who have cystic fibrosis.

Payment for Inpatient Mental Health Care

For inpatient mental health care, the DRG payment system isn't used in certain mental health facilities that are DRG-exempt. Instead, all TRICARE-eligible patients, other than active-duty family members, will pay 25 percent of a specific per diem rate for the hospital to which they have been admitted.

Here's an example of how the inpatient cost-sharing system works for an ***active-duty family*** without other health insurance: Captain Conrad's daughter, Linda, needed to have her appendix out. Since the Conrads did not live near a military hospital, Linda went to a local civilian hospital.

The hospital was required by law to participate in TRICARE Standard. Linda's surgeon, Dr. Miller, also agreed to participate. This means that they agreed to accept the TRICARE Standard allowable charge as the full fee for the care they provided.

Fortunately, Linda's operation was simple, and she had to stay in the hospital for only three days. After she went home, the hospital and Dr. Miller sent Linda's claim forms to the TRICARE contractor.

Hospital and Doctor Both Participate	
Hospital Fee Under Participation:	$1,800.00
Dr. Miller's Fee Under Participation:	$1,200.00
Total:	$3,000.00
Linda's Stay: (Active Duty: $9.90 x 3 Days)	$29.70
TRICARE Standard Pays:	$2,970.30
Linda's Family Pays:	$29.70 + TV Fee

The charge for Linda's covered hospital care under the DRG payment system was $1,800. And the claims processor knew the allowable cost for Dr. Miller's services was $1,200. Linda had stayed at the hospital for three days. Since the daily inpatient fee was $9.90 at the time, the total for three days was $29.70. So, the processor sent a check to Dr. Miller for $1,200, a check to the hospital for $1,770.30, and sent a notice to the Conrads that they owed the hospital $29.70. They also had to pay the hospital for items like the TV in Linda's room that were not covered by TRICARE Standard.

Here's an example of how inpatient cost-sharing works for a retiree: Commander Roberts, a retired Navy officer, needed back surgery. Since he lived in a ZIP code zone near a military hospital, he checked to see if he could have the operation there. The hospital did not have the facilities for such an operation. So, the military hospital filed a nonavailability statement electronically with the DEERS computerized eligibility checking system, and Commander Roberts found a civilian hospital where he could have the surgery.

The hospital participated in TRICARE Standard for the commander's care. And his surgeon, Dr. Jacobs, also agreed to accept TRICARE Standard payment for his services.

The operation went well, but because of some minor complications, Commander Roberts stayed in the hospital for a week. The hospital and Dr. Jacobs sent the claim forms to the TRICARE contractor. The covered hospital charges came to $10,000. And the doctor's allowable charges were $4,000.

TRICARE Standard paid the DRG-specific amount, which was $9,000, minus the commander's cost-share of $2,500, for a total of $6,500. (Remember that under the DRG payment system, Commander Roberts, as a retiree, would pay the lesser of 25 percent of the hospital's $10,000 bill, which is $2,500, or $360 per day times the number of days (seven) that he spent in the hospital, which comes to $2,520. Since $2,500 is less than $2,520, the smaller amount is all he had to pay.) So, the contractor sent a check to the hospital for $6,500 ($9,000 minus $2,500) and a check to Dr. Jacobs for $3,000 (75 percent of the doctor's allowable cost). The TRICARE contractor also sent a notice, or Explanation of Benefits, to Commander Roberts telling him that he would have to pay the hospital the other $2,500, and that he would have to pay Dr. Jacobs $1,000 (25 percent of the doctor's allowable charges). Fortunately, Commander Roberts had supplemental insurance to help cover his cost-share.

Inpatient Cost-Sharing for a Retiree	
Hospital Bill:	$10,000.00
Surgeon's Fee:	$4,000.00
TRICARE Standard Share of Hospital Bill under DRG System:	$6,500.00
TRICARE Standard Share of Surgeon's Fee:	$3,000.00
Cmdr. Roberts' Share of:	
Hospital Bill	$2,500.00
Surgeon's Fee	$1,000.00

Note:

Because the DRG amount is based on national average costs, the TRICARE Standard amount for hospital care sometimes might be more than a particular hospital charges for a certain type of care. In the example above, the TRICARE Standard DRG rate for the care might be, say, $11,000 instead of $9,000. Even though the hospital's bill for the care was only $10,000, TRICARE Standard would pay the hospital 75 percent of $11,000—or a total of $8,250. Commander Roberts still pays 25 percent of the hospital's billed charges, or $2,500.

Inpatient Costs With Providers Who Don't Participate in TRICARE Standard

It's very rare that a hospital does not participate in TRICARE Standard for inpatient care. If this should happen to you, contact your Health Benefits Adviser for help.

Remember:

All hospitals that participate in Medicare must, by law, also participate in TRICARE Standard for inpatient services related to hospital admissions.

But be aware that just because a civilian hospital participates does not mean that the doctors or other providers of care (such as anesthetists) who treat you at that hospital will. The hospital may participate while some doctors or other providers may not, because they are not employees or contractors of the hospital.

Remember, if the doctor doesn't participate, the bill may be for more than the TRICARE Standard allowable charge. You arrange with the doctor how and when to pay the bills.

If the provider of care doesn't participate in TRICARE Standard and refuses to file the claim, you may have to fill out and file the claim form. Get a fully itemized bill. Then sign and send the form and a copy of the bill to your TRICARE contractor. TRICARE Standard can then pay you what it would have paid the doctor had the doctor participated in TRICARE Standard. (See the section titled "Fully Itemized Bills" in the "How to File a Claim" chapter.)

For families of active-duty members, TRICARE Standard pays the allowable charge. You pay anything over that, up to

the legal limit of 15 percent above the TRICARE maximum allowable charge.

For retirees, their families, some former spouses, and the families of service members who have died, TRICARE Standard pays 75 percent of the allowable charge for the doctors' services. You pay 25 percent plus anything over the allowable charge, up to the legal limit. (See the exception for this category of eligible persons at the beginning of the "Who's Covered?" chapter.)

All families also pay the full amount for any care that is not covered by TRICARE Standard.

Other Health Insurance

If you have other health insurance in addition to your TRICARE Standard benefits, TRICARE Standard pays after all other plans you may have, except for Medicaid (a public assistance program), benefits under a State Victims of Crime Compensation Program, and certain insurance policies that are specifically designated as **TRICARE supplements.**

This means that if you have another health plan in addition to TRICARE Standard, the other plan must pay whatever it covers before TRICARE Standard will make any type of payment. You may have coverage for yourself and your family through an employer, an association, or a private insurer. This also includes the medical portion of an auto insurance policy, or any coverage that students in the family may have through their schools.

When your other plan has paid, then TRICARE Standard will pay for covered outpatient services, within certain limits.

Here are two examples of how the government determines its payment for your covered civilian health care (both examples assume that you have already satisfied your annual outpatient deductible):

First Example:

If you go to a provider of care who *participates* in TRICARE Standard, the TRICARE contractors will pay the *lesser* of:

1. The amount of the provider's billed charges, *minus* the other health insurance's payment; *or*
2. The amount that TRICARE Standard *would* have paid if you didn't have any other primary health insurance.

Here's an illustration of the above example: *The participating doctor bills you $100, which is the same as the TRICARE Standard allowable charge for the care. Your other insurance pays $80, leaving $20 unpaid. Since you're a military retiree, the TRICARE Standard share of the doctor's bill would be $75 if you didn't have other insurance. Since you do have other insurance, TRICARE Standard will pay whichever amount—$75 or $20—is less. So, in this illustration, TRICARE Standard pays the $20 that your other insurance didn't cover.*

Second Example:

If you go to a *non-participating* provider—one who does not accept the TRICARE Standard allowable charge as the full fee for the care provided, and may charge more for your care—the TRICARE contractors will pay the *lesser* of:

1. An amount up to 15 percent *more* than the TRICARE Standard allowable charge, *minus* the amount your other health insurance paid; *or*

1. The amount that TRICARE Standard *would* have paid if you didn't have any other health insurance.

Here's an illustration of the second example: *Although the allowable charge for the care is $100, the non-participating doctor bills you $150. Your other insurance pays $125 of that, leaving $25 unpaid. The TRICARE Standard share of the doctor's bill would be $75—that is, 75 percent of the allowable charge—if you didn't have other insurance. Since you* ***do*** *have other insurance, and it paid $125, TRICARE Standard will pay nothing.*

Why? Because the TRICARE Standard payment for care received from a non-participating provider, when you have other insurance, is limited to 15 percent above the allowable charge (in this case, $115), minus the amount your other insurance paid (in this case, $125). Since the other insurance paid ***more*** *than $115, TRICARE Standard won't pick up any of the rest of the charges.*

Of course, you are responsible for any unpaid amounts the provider has not been paid for TRICARE-covered services, but only up to the legal limit of 15 percent above the allowable charge. In the second illustration (above), the non-participating provider has been paid more than 15 percent above the $100 allowable charge, so you would owe nothing. In this illustration, you would not be legally liable for more than $115 in medical bills.

You must, however, pay all charges for care that aren't covered by TRICARE Standard.

For ***inpatient*** care in hospitals subject to the TRICARE Standard DRG payment system, payments will be limited to the DRG amount or whatever part of it remains after your other health plan has paid everything it's going to pay.

Sometimes your other plan will pay your entire claim, leaving nothing for TRICARE Standard to pay. You should still have the claim submitted to your TRICARE contractor, even though TRICARE Standard won't pay anything if the other plan paid the whole bill. This will ensure that the amounts paid by the other plan are counted toward your TRICARE Standard deductible, so you won't be charged the full deductible on other claims you submit to TRICARE. It will also help ensure that the amounts paid by the other plan are counted toward the cost cap explained at the beginning of this chapter.

Or, the other plan may pay nothing if it doesn't cover the care you received. You still must have the claim filed with your other plan first, and get an Explanation of Benefits from them, which must be sent in with your TRICARE Standard claim. Then, TRICARE Standard will process your claim and pay its share of your care that's covered under TRICARE Standard.

TRICARE-eligible persons who also have medical coverage through an HMO may have TRICARE Standard cost-share expenses under the same rules as for other health plans that pay before TRICARE Standard.

Caution*: Families who have an HMO (health maintenance organization) as their other health insurance can't jump between the HMO and TRICARE Standard. All covered health care services must be obtained from the HMO.*

When TRICARE Pays Incorrectly

Sometimes, in the processing of more than 20 million claims a year, TRICARE contractors inadvertently overpay claims. The overpayment might go to the patient or to the health care provider, depending on who submitted the claim or on whether or not the provider agreed to participate in TRICARE Standard on the claim.

Or, a contractor might mistakenly share the cost of care under TRICARE Standard for someone who isn't TRICARE-eligible.

Or, a contractor might pay for care that was given by a provider who wasn't authorized to treat TRICARE patients.

Or, a claim might be submitted—and paid by the TRICARE contractor—that bills for services that were not provided to a patient, or that bills twice for the same services, or that bills for services that are not a benefit under TRICARE.

When any of these things happens—no matter whose fault the incorrect payment was—the TRICARE contractor must take action to get the money back from the person or organization who received the erroneous payment. That's called "recoupment," and it's done to help ensure that your tax dollars are spent properly, according to the law.

Here's what will happen: The contractor will send a written request for repayment of the amount in question. The request will also explain all of your rights under the law, including any right you may have to appeal the denial of TRICARE benefits, and all actions that the contractor may take to get the money back. You should respond to a repayment request within 30 days after you've received it.

Important: Do not ignore a letter that asks you to repay money that was wrongly sent to you. Answer it promptly.

If the overpayment wasn't your fault, the TRICARE contractor will make every effort to help you get your debt repaid. If you can't afford to pay the money all at once, you may be able to make monthly payments. You'll be asked to complete a financial statement, and—depending on your situation—the TRICARE contractor may consider reducing the debt or waiving collection altogether.

If you ignore the letters asking for repayment, any of several things could happen:

1. The amount could be subtracted from any money you might have coming from future TRICARE Standard claims;

1. The TRICARE contractor may take legal action against you, as permitted by state law.

Emergency Room Charges

TRICARE cost-shares emergency room charges on an inpatient basis when the intent was to admit the patient to the hospital once his or her condition was stabilized in the emergency room, but the patient died before being formally admitted. The change from outpatient to inpatient cost-sharing in this situation means that TRICARE begins paying with the first dollar of medical bills, instead of waiting until the family has satisfied the annual outpatient deductible.

How to File a Claim

Do You Have Other Insurance?

Are you covered by other health insurance—maybe through your husband or wife, maybe through a job, or under medical coverage for accidental injuries under your automobile insurance policy? If so, you or your provider must file a claim for your health care with the insurance plan before filing with TRICARE Standard. After your other health insurance has decided what it's going to pay, a claim may be filed with TRICARE Standard. A copy of the other health plan's payment determination, and a copy of the bill, must be sent along with your TRICARE Standard claim.

Some providers, even if they agree to participate in TRICARE Standard, may ask you to file with the other insurance first. Discuss this with them when you arrange to pay your part of the bills. If you have TRICARE Standard supplemental insurance—a policy that's specifically designated to be a supplement to TRICARE Standard health benefits, and is sold by many military associations and some private firms—you don't file with them first. Go ahead and have the claim sent to the TRICARE contractor. Make sure that the name of your insurance and other information about the policy is indicated on the claim form.

If you don't tell the TRICARE contractor about your other health insurance, the claim your provider sends in could be delayed in processing or even denied.

Were You Injured in an Accident?

Were you hurt in a car crash, on the job, or in any other type of accident, such as a slip-and-fall, where someone else may be legally responsible (for example, the other driver or your employer)? If so, they or their insurance may have to pay some or all of the medical bills. You or the provider can file claims with TRICARE right away, but be sure to point out on the claim that another person may be responsible. You'll have to complete and attach DD Form 2527, Statement of Personal Injury—Possible Third Party Liability. It's available from your HBA or from your TRICARE contractor. This will also speed up the processing of your TRICARE Standard claim.

If a TRICARE Standard claim appears to involve an injury, and the Form 2527 is not attached, the contractor will write back, sending a blank "2527" and asking for information on the circumstances of the injury. If you don't provide the information, your claim will be denied. Don't ignore this form, even if some of the questions on it don't seem to apply to your situation. Even if your accident wasn't caused by someone else, there may be other insurance available to cover part of the cost. For example, you may have a medical benefit as part of your auto insurance or homeowner's liability insurance, or you may be covered by workers' compensation. Be sure to point out this kind of coverage on your TRICARE Standard claim. If you have insurance that pays ***before*** TRICARE Standard does, the TRICARE contractor will not pay your claim until you provide

evidence of the amount the other insurance paid toward your medical expenses.

When your other insurance has paid, TRICARE Standard will then pay its share of the costs as your secondary coverage. The following types of coverage are primary to TRICARE Standard and must pay before TRICARE Standard does:

1. Workers' compensation;
2. Personal injury protection under your auto insurance policy;
3. Coverage under the no-fault or uninsured motorist provisions of your auto insurance policy.

Are You "On DEERS"?

If you don't appear in the DEERS data bank as eligible for TRICARE benefits, TRICARE Standard will deny your claim. (See the end of the "Who's Covered?" chapter for details about DEERS.)

It's Important to Fill Out a Claim Form Correctly

The TRICARE/CHAMPUS contractors get thousands of claims every day. The claims are computer-processed for speed in paying you or your health care provider. Any mistake, forgotten signature or other missing information can slow down your claim because the contractor may have to call or write back to get the needed information.

Which Claim Form to Use

If your doctor files the claim, he or she will generally send in a completed HCFA 1500 claim form. When the hospital files the claim, as it must for inpatient care, it will use the UB-92 claim form.

If you file the claim, you'll have to submit a DD Form 2642 ("CHAMPUS Claim—Patient's Request for Medical Payment"). Be sure to attach a copy of the provider's itemized bill to the claim form.

Form	*Use*
DD Form 2642	For care from doctors and other individual providers; sent in by patient/family.
HCFA 1500	For care from doctors and other individual providers; sent in by provider.
UB-92	For inpatient or outpatient care from hospitals and other institutions. The hospital or other institution completes the UB-92. Outside the United States and Puerto Rico, the DD Form 2520 (the "old" yellow CHAMPUS claim form that was formerly used by patients to file claims) is still used for care from hospitals and institutions.

Where to Get the Form

Many providers already have the CHAMPUS forms on hand. You can also get forms from your Health Benefits Adviser, TRICARE Service Center or TRICARE contractor.

What Goes in Along with the Claim?

One or more of the following may need to go in with the claim. If they are not provided to the TRICARE contractor when needed, your claim could be denied or delayed. So read this section very carefully.

When your provider files the claim for your care, you may have to get these papers together for the provider, and perhaps have the nearest military hospital file the nonavailability statement electronically. Be sure to make copies of paper documents and keep the originals for yourself, except the claim form—make sure the original claim form is sent in, and keep a copy for yourself.

All attachments should be sent in with each claim, even if a claim was previously filed for similar services during the same course of treatment.

- Nonavailability Statement

  If you live within the ZIP code zone (in Europe or elsewhere outside the 50 states and Puerto Rico, it's a 40-mile radius) around a military hospital, that hospital must file a nonavailability statement electronically with the Defense Department's DEERS computer files for inpatient care at a civilian hospital (except for emergency care). This includes

claims for a doctor's services while you were an inpatient, and for inpatient maternity care.

For some highly specialized types of treatment, the ZIP code zone may be much wider (perhaps 200 miles), or even nationwide. Check with your nearest HBA or TRICARE Service Center before getting care under TRICARE to be sure you've followed the rules for getting an NAS.

Note:

*If you have another health insurance policy that pays **first** for the cost of medical services, you don't have to get a nonavailability statement from the local military hospital.*

Important:

In late 1996, there were significant changes to the rules about when—and for what—you need an NAS. For details about these changes, see the chapter titled "Where to Get Care." Also note the information in the same chapter and in the chapter titled "What's Covered?" about authorizations needed for certain types of care.

➤ **Statement from another insurance plan**

If you have other insurance (other than a TRICARE supplement), their statement of how much they paid must be attached to the TRICARE Standard claim. This includes coverage under your auto insurance and workers' compensation. If the other plan doesn't pay, you must provide the exclusion section of their policy or a copy of their denial along with your claim. A denial from an HMO or PPO

(preferred provider organization) that states you did not use the available services does not count as an exclusion.

- **DD Form 2527 (personal injury questionnaire)**

  If you had to go to a hospital (or have a doctor bill of $500 or more) as a result of an accidental injury, you should complete a DD Form 2527 and include it with your claim. It's a questionnaire about how the accident happened. It's needed to complete the processing of your claim. Get a copy from your HBA or TRICARE contractor.

- **Fully itemized bills**

  Photocopies of fully itemized bills must be sent along with your claim. These must be included even if your other health insurance has made payment and their Explanation of Benefits (EOB) is enclosed.

  A fully itemized bill shows the cost for each service or supply you received.

The bill must be on the provider's stationery. And it must show:

1. Name of the patient;
2. Diagnosis or description of symptoms. For prescription drugs, this is required only if the claim meets one or more of the following conditions: more than 20 prescriptions on the claim; more than $250 in drug charges on the claim; more than $150 in drug charges for any one month; more than four prescriptions for the same controlled drug in a given month; and others. Check with your HBA or TRICARE Service Center;

3. Each item of service or supply;
4. Place of service;
5. Number/frequency of each service;
6. Date of care;
7. Charge for each item of service or supply.

Bills for prescription drugs must be on the pharmacy's letterhead or billing form, and must also show:

1. Name of the drug;
2. Strength of the drug;
3. How much of the drug you bought (the number of pills or amount of other medicine);
4. Cost of each drug (except prepaid prescription plans);
5. Prescription number and date prescription was filled;
6. Name and address of the prescribing doctor;
7. Name and address of the pharmacy.

TRICARE will not accept canceled checks or cash register receipts. These are not fully itemized bills.

Always make copies of documents that go in with the claim, and keep the originals of these documents for yourself.

Daily Nursing Notes

If you get care from a private duty nurse, copies of the daily nursing notes must be sent along with your claim. The claim

should also show which doctor referred you for private nursing and is supervising the care. This is true for all private duty nursing care, whether it was at home or in a hospital. (See the "Private Duty or Visiting Nurses" section in the chapter titled "What's Covered?")

Doctor's Prescription

For medical supplies (such as syringes, needles, catheters, ostomy bags, etc.) or medical equipment costing $100 or less (such as crutches), a doctor's prescription must go in with your claim. For durable medical equipment worth more than $100 (such as wheelchairs or respirators), the prescription must spell out the particular type of equipment needed, and why and how long you need the equipment. (See the "Durable Medical Equipment" section in the "What's Covered?" chapter.)

Program for Persons with Disabilities

See the next section for information about what must be sent to the TRICARE claims processor with Program for Persons with Disabilities claims.

Helpful Hints for Filing Claims

1. All receipts should be on (or attached to) 8-1/2" x 11" sheets of paper;
2. Include your sponsor's Social Security Number on all pieces of correspondence and attachments to claims;
3. **Do not highlight information** on documents with a "highlighter" or "magic marker." It is either lost in

scanning or blackens the information you want to emphasize. ***Circle*** the information instead.

Where to Send the Claim

If you live in a TRICARE area, send claims to the contractor for the area where you live. If TRICARE hasn't come to your area yet, claims go to the contractor for the state or country where you received the care, no matter where you live. Remember this when you're traveling.

Here are up-to-date (as of August 1997) TRICARE claims filing addresses for U.S. and overseas areas. These addresses may change, so check them before having claims sent in: (See the "A Look at TRICARE" chapter in the front of the book to find out when TRICARE is expected to come to your area.)

- **Alabama (TRICARE area)**—Palmetto GBA, P.O. Box 202000, Florence, SC 29502-2000. Toll-free phone: 1-800-403-3950.
- **Alaska**—Palmetto GBA, CHAMPUS claims, P.O. Box 870001, Surfside Beach, SC 29587-0001. Toll-free phone: 1-800-930-2929.
- **Arizona (TRICARE area)** (***except*** for the Yuma area)—Palmetto GBA, P.O. Box 870026, Surfside Beach, SC 29587-8726. Toll-free phone: 1-800-225-4816.
- **Arkansas (TRICARE area)** (***except*** a small part of Arkansas in the Naval Hospital, Millington, Tenn., service area)—WPS, P.O. Box 8999, Madison, WI 53708-8999. Toll-free phone: 1-800-406-2832. The Millington area's

address is: Palmetto GBA, P.O. Box 202000, Florence, SC 29502-2000. Toll-free phone: 1-800-403-3950.

- **California (TRICARE area)** (***including*** the Yuma, Ariz., area)—Palmetto GBA, CHAMPUS Claims, P.O. Box 870001, Surfside Beach, SC 29587-8701. Toll-free phone: 1-800-930-2929.
- **Colorado (TRICARE area)**—Palmetto GBA, P.O. Box 870027, Surfside Beach, SC 29587-8727. Toll-free phone: 1-800-225-4816.
- **Connecticut**—Unisys, P.O. Box 3066, Columbus, IN 47202-3066. Toll-free phone: 1-888-999-5195. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **Delaware**—Unisys, P.O. Box 3076, Columbus, IN 47202-3076. Toll-free phone: 1-888-999-5195. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **District of Columbia**—Palmetto GBA, P.O. Box 100502, Florence, SC 29501-0502. Toll-free phone: 1-800-578-1294. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **Florida, Georgia (TRICARE areas)**—Palmetto GBA, P.O. Box 202000, Florence, SC 29502-2000. Toll-free phone: 1-800-403-3950.
- **Hawaii (TRICARE area)**—Palmetto GBA, CHAMPUS Claims, P.O. Box 870001, Surfside Beach, SC 29587-0001. Toll-free phone: 1-800-930-2929.

- **Idaho (TRICARE area)** (***except*** for the six Idaho counties listed below)—Palmetto GBA, P.O. Box 870028, Surfside Beach, SC 29587-8728. Toll-free phone: 1-800-225-4816.
- **Idaho (TRICARE area)** (these six Idaho counties only: Benewah, Bonner, Boundary, Kootenai, Latah, Shoshone) —FHFS TRICARE-NW, P.O. Box 8929, Madison, WI 53708-8929. Toll-free phone: 1-800-404-0110.
- **Illinois**—Unisys, P.O. Box 3054, Columbus, IN 47202-3054. Toll-free phone: 1-888-999-5195. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **Indiana**—Unisys, P.O. Box 3056, Columbus, IN 47202-3056. Toll-free phone: 1-888-999-5195. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **Iowa (TRICARE area)**—Palmetto GBA, P.O. Box 870029, Surfside Beach, SC 29587-8729. Toll-free phone: 1-800-225-4816.
- **Kansas (TRICARE area)**—Palmetto GBA, P.O. Box 870030, Surfside Beach, SC 29587-8730. Toll-free phone: 1-800-225-4816.
- **Kentucky** (***except*** Fort Campbell area)—Palmetto GBA, CHAMPUS Claims, P.O. Box 100598, Florence, SC 29501-0598. Toll-free phone: 1-800-493-1613. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **Kentucky** (Fort Campbell area only)—WPS, P.O. Box 7889, Madison, WI 53707-7889. Toll-free phone: 1-800-

866-6337. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.

- **Louisiana (TRICARE area)** (western two-thirds, mainly west of Baton Rouge)—WPS, P.O. Box 8999, Madison, WI 53708-8999. Toll-free phone: 1-800-406-2832.
- **Louisiana (TRICARE area)** (eastern third of the state, including Baton Rouge and New Orleans)—Palmetto GBA, P.O. Box 202000, Florence, SC 29502-2000. Toll-free phone: 1-800-403-3950.
- **Maine**—Unisys, P.O. Box 3064, Columbus, IN 47202-3064. Toll-free phone: 1-888-999-5195. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **Maryland**—Palmetto GBA, P.O. Box 100502, Florence, SC 29501-0502. Toll-free phone: 1-800-578-1294. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **Massachusetts**—Unisys, P.O. Box 3063, Columbus, IN 47202-3063. Toll-free phone: 1-888-999-5195. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **Michigan**—UNISYS, P.O. Box 3053, Columbus, IN 47202-3053. Toll-free phone: 1-888-999-5195. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **Minnesota (TRICARE area)**—Palmetto GBA, P.O. Box 870029, Surfside Beach, SC 29587-8729. Toll-free phone: 1-800-225-4816.

- **Mississippi (TRICARE area)**—Palmetto GBA, P.O. Box 202000, Florence, SC 29502-2000. Toll-free phone: 1-800-403-3950.
- **Missouri (*except* the St. Louis area) (TRICARE area)**—Palmetto GBA, P.O. Box 870030, Surfside Beach, SC 29587-8730. Toll-free phone: 1-800-225-4816.
- **Missouri** (the St. Louis area)--WPS, P.O. Box 8932, Madison, WI 53708-8932. Toll-free phone: 1-800-388-6767. (***Note***: The St. Louis area will become part of TRICARE Region 5; TRICARE will start in mid-1998.)
- **Montana (TRICARE area)**--Palmetto GBA, P.O. Box 870031, Surfside Beach, SC 29587-8731. Toll-free phone: 1-800-225-4816.
- **Nebraska (TRICARE area)**--Palmetto GBA, P.O. Box 870027, Surfside Beach, SC 29587-8727. Toll-free phone: 1-800-225-4816.
- **Nevada (TRICARE area)**--Palmetto GBA, P.O. Box 870033, Surfside Beach, SC 29587-8733. Toll-free phone: 1-800-225-4816.
- **New Hampshire**—Unisys, P.O. Box 3067, Columbus, IN 47202-3067. Toll-free phone: 1-888-999-5195. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **New Jersey**—Unisys, P.O. Box 3052, Columbus, IN 47202-3052. Toll-free phone: 1-888-999-5195. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.

- **New Mexico (TRICARE area)**—Palmetto GBA, P.O. Box 870032, Surfside Beach, SC 29587-8732. Toll-free phone: 1-800-225-4816.
- **New York**—Unisys, P.O. Box 3050 (for ZIP codes 13000-14999), or P.O. Box 3051 (for ZIP codes 10000-12999), Columbus, IN 47202-3050 (for ZIPs 13000-14999), or 47202-3051 (for ZIPs 10000-12999). Toll-free phone: 1-888-999-5195. ***Note***: New TRICARE contractor in mid-1998. Mailing address/toll-free phone number will change.
- **North Carolina**—Palmetto GBA, P.O. Box 100502, Florence, SC 29501-0502. Toll-free phone: 1-800-493-1613. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **North Dakota (TRICARE area)**—Palmetto GBA, P.O. Box 870031, Surfside Beach, SC 29587-8731. Toll-free phone: 1-800-225-4816.
- **Ohio**—Palmetto GBA, CHAMPUS Claims, P.O. Box 100598, Florence, SC 29501-0598. Toll-free phone: 1-800-493-1613. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **Oklahoma (TRICARE area)**—WPS, P.O. Box 8999, Madison, WI 53708-8999. Toll-free phone: 1-800-406-2832.
- **Oregon (TRICARE area)**—FHFS TRICARE-NW, P.O. Box 8929, Madison, WI 53708-8929. Toll-free phone: 1-800-404-0110.
- **Pennsylvania**—For ZIP codes 15001-15299 and 19001-19199: Unisys, P.O. Box 3074, Columbus, IN 47202-3074.

For all other cities: Unisys, P.O. Box 3075, Columbus, IN 47202-3075. Toll-free phone: 1-888-999-5195. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.

- **Rhode Island**—Unisys, P.O. Box 3065, Columbus, IN 47202-3065. Toll-free phone: 1-888-999-5195. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **South Carolina (TRICARE area)**—Palmetto GBA, P.O. Box 202000, Florence, SC 29502-2000. Toll-free phone: 1-800-403-3950.
- **South Dakota (TRICARE area)**—Palmetto GBA, P.O. Box 8700031, Surfside Beach, SC 29587-8731. Toll-free phone: 1-800-225-4816.
- **Tennessee (TRICARE area)**—Palmetto GBA, P.O. Box 202000, Florence, SC 29502-2000. Toll-free phone: 1-800-403-3950.
- **Texas (TRICARE area)** (***except*** southwestern corner of state that includes El Paso, and the Cannon Air Force Base, N.M., service area ZIP codes that fall in Texas)—FHFS, c/o WPS/TRICARE, P.O. Box 8999, Madison, WI 53708-8999. Toll-free phone: 1-800-406-2832.
- **Texas (TRICARE area)** (southwestern corner including El Paso, and Cannon Air Force Base, N.M., ZIP codes that fall in Texas)—Palmetto GBA, P.O. Box 870032, Surfside Beach, SC 29587-8732. Toll-free phone: 1-800-225-4816.

- **Utah (TRICARE area)**—Palmetto GBA, P.O. Box 870032, Surfside Beach, SC 29587-8732. Toll-free phone: 1-800-225-4816.
- **Vermont**—Unisys, P.O. Box 3068, Columbus, IN 47202-3068. Toll-free phone: 1-888-999-5195. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **Virginia**—Palmetto GBA, P.O. Box 100502, Florence, SC 29501-0502. Toll-free phone: 1-800-493-1613. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **Washington (TRICARE area)**—FHFS TRICARE-NW, P.O. Box 8929, Madison, WI 53708-8929. Toll-free phone: 1-800-404-0110.
- **West Virginia**—Palmetto GBA, CHAMPUS Claims, P.O. Box 100598, Florence, SC 29501-0598. Toll-free phone: 1-800-493-1613. ***Note***: New TRICARE contractor in mid-1998. Mailing address/toll-free phone number will change.
- **Wisconsin**—Palmetto GBA, P.O. Box 100598, Florence, SC 29501-0598. Toll-free phone: 1-800-493-1613. ***Note***: New TRICARE contractor in mid-1998. Mailing address and toll-free phone number will change.
- **Wyoming (TRICARE area)**—Palmetto GBA, P.O. Box 870030, Surfside Beach, SC 29587-8730. Toll-free phone: 1-800-225-4816.
- **Puerto Rico**—WPS, P.O. Box 7985, Madison, WI 53707-7985. Telephone: (608) 259-4847.

- **Europe, Africa, Middle East** (plus active-duty members' foreign claims)—WPS, P.O. Box 8976, Madison, WI, USA 53708-8976. Telephone: (608) 259-4847.
- **Canada, Mexico, Central America, South America, Bermuda, West Indies, Pacific area (China, Thailand, Korea, Australia, Japan, etc.)—**WPS, P.O. Box 7985, Madison, WI, USA 53707-7985. Phone: (608) 259-4847.
- **Adjunctive dental claims** (world-wide)—within the continental U.S., claims in TRICARE areas should be sent to the specific TRICARE contractors. In non-TRICARE areas, claims should be sent to: Palmetto GBA, P.O. Box 100599, Florence, SC 29501-9599. Telephone: (803) 665-2320. Outside the continental U.S., claims (including those for persons traveling outside the U.S., and claims for active-duty service members who are under TRICARE Europe) should go to: WPS, P.O. Box 8976, Madison, WI USA 53708-8976. Telephone: (608) 259-4847.
- **Christian Science claims** (except TRICARE areas)—UNISYS, ATTN: Christian Science, P.O. Box 3063, Columbus, IN 47202-3063. Toll-free phone: 1-888-999-5195. Christian Science claims for services in regions where TRICARE is in operation should be sent to the TRICARE contractor for a given region.

Abbreviations of the names of TRICARE contractors in the above listings stand for the following:

- **Unisys**: Unisys Corporation—Health Information Management Service Center (formerly AdminaStar Defense Services)

- **TriWest**: TriWest Healthcare Alliance. (TriWest is the TRICARE contractor for Nevada, Arizona, New Mexico, Colorado Utah, Wyoming, Montana, North and South Dakota, Nebraska, Kansas, Minnesota, Iowa, Missouri, all of Idaho except the following counties: Benewah, Bonner, Boundary, Kootenai, Latah and Shoshone; and the southwestern corner of Texas that includes El Paso. TriWest has subcontracted its claims processing operations to Palmetto GBA. That's why Palmetto is listed for the above states, instead of TriWest.)
- **WPS**: Wisconsin Physicians Service
- **FHFS**: Foundation Health Federal Services
- **Humana**: Humana Military Healthcare Services. (Humana is the TRICARE contractor for Florida, Georgia, South Carolina, Alabama, Mississippi, Tennessee, the eastern third of Louisiana, and a small part of Arkansas near the Naval Hospital in Millington, Tenn. Humana has subcontracted its claims processing operations to Palmetto GBA. That's why Palmetto is listed for the above states, instead of Humana.)
- **Palmetto GBA**: Palmetto Government Benefits Administrators

When the Claim Should Be Sent in

You or your provider of care should send your TRICARE Standard claim forms to the TRICARE contractor as soon as possible after you get care. The sooner your TRICARE contractor gets the claim forms and other papers, the sooner you or your provider will be paid.

Claims must be received by the contractor within one year of the date the service was received—or, in the case of inpatient care, within one year of the date of an inpatient's discharge.

What the Submitter Gets Back and How Long It Takes

If everything is okay with your claim, the contractor should send whomever filed the claim a notice called an Explanation of Benefits (EOB) in about a month. The EOB shows:

- What the provider billed;
- The TRICARE Standard allowable charge at the time of care;
- How much of your annual deductible has been met;
- How much you've paid toward your annual cost cap;
- Your cost-share for the care;
- How much TRICARE paid.

If your provider did not agree to participate in TRICARE Standard and didn't file the claim for you, you also get a check for the TRICARE Standard cost-share. It's your responsibility, of course, to make sure that the provider's bill is paid.

The EOB also gives the reasons for denying services on a claim.

If the claims processor needs additional information, you may get a phone call or letter. If so, you must get that informa-

tion to the processor within 35 days of the date of the letter or phone call, or else your claim may be denied.

Keep Copies or Originals of Claims and Papers

Keep a copy of the claim and the originals of all other documents that are sent to TRICARE. Even if your provider files the claim, it's a good idea to keep your own copies.

Suppose your claim forms and papers get lost in the mail? Or suppose you have questions about your claim? Or suppose you think the contractor has made a mistake with your claim? You will need to have your own copies to support your claim for reimbursement.

Program for Persons with Disabilities

Be Aware of These Important Points

- The Program for Persons with Disabilities (PFPWD) is only for seriously disabled persons who are ***dependents of active-duty members*;**
- You must ***apply and get approval*** before TRICARE Standard can help pay the costs of care;
- You should check with your nearest Health Benefits Adviser or TRICARE Service Center (TSC) before applying for benefits under the program;
- Sometimes, ***not*** using PFPWD benefits for diagnostic and treatment services can save you money. The PFPWD benefit is generally limited to $1,000 per month. You may instead be able to get these services under the basic TRICARE Standard program, where you may have to pay only a maximum of $1,000 in a fiscal year (this is the "catastrophic cap" on expenses for active-duty families);
- But if you decide to use PFPWD for the needed services, and your costs exceed the $1,000 monthly limit, those amounts in excess of the limit under PFPWD may not be cost-shared by TRICARE Standard under the basic

program. Because of this, it is very important to work closely with your HBA or TSC when considering using these benefits. (See the beginning of the chapter titled "How Much Will It Cost?" for details on the catastrophic cap.)

- Enrollment in TRICARE Prime does not affect a person's eligibility to receive services under PFPWD.

Who Qualifies?

The Program for Persons with Disabilities serves persons with two kinds of serious disabilities: persons who have moderate or severe mental retardation, and those who have a significant physical disability.

Remember:

The person must be a dependent of an active-duty member.

Public Funds and Facilities Must Be Either Unavailable or Insufficient to Meet the Patient's Disability-Related Needs

In many communities, public funds are available for persons with disabilities. If so, you must get assistance this way first. Your HBA or TSC may be able to help you find out about help available in your community.

If public help isn't available or isn't enough, TRICARE Standard helps pay for covered services. But you must include with your request for PFPWD benefits a letter from the proper

public official saying why public help is unavailable or insufficient. If you don't know who the right public official is, contact an HBA or your TSC.

Note:

As with the rest of the TRICARE program, all providers of services or supplies/equipment must be authorized. See the section titled "Where and From Whom Can You Get Care under TRICARE Standard" in the "Where to Get Care" chapter.

You Must Apply

Active-duty family members, or persons acting on their behalf, who apply for benefits under the TRICARE PFPWD must show that the medical condition qualifies them for the program and that the requested benefits are necessary and appropriate. If your PFPWD-eligible family member is diagnosed with a medical condition requiring care beyond the scope of your nearest uniformed services hospital, talk with the HBA or TSC to determine whether the family member might be eligible for care under the PFPWD.

All program benefits must be authorized in advance. Contact your Health Benefits Adviser or TRICARE contractor for guidelines on the type of information required to establish the existence of a qualifying medical condition and to establish the need for the benefits required.

Claims for Pre-Authorized Benefits

All benefits under the program must be authorized in writing by TRICARE before any services, supplies or equipment are received. A copy of the authorization must be attached to the claim form.

For all services and supplies under the PFPWD, individual providers of care must send in the HCFA 1500 claim form; institutional providers will use the UB-92 form. ***In areas where the TRICARE program is in operation***, the claims should be sent to the TRICARE contractor for the state where the patient lives. ***Where TRICARE has not yet begun operation***, the claims should be sent to the contractor for the state where the care was received.

For general medical care of the disabled person, patients or their family members who must file claims will use the DD Form 2642 (“Patient’s Request for Medical Payment”). Providers will use the forms listed in the preceding paragraph. Anyone under the Program for Persons with Disabilities—no matter what age—is covered for general medical care as described in the rest of this handbook.

If the Active-Duty Member is Transferred

New benefit approvals must be obtained after you move. Contact the HBA or TSC at your new location to help with the transition of these benefits.

Changing Health Care Providers

If you need to change the provider listed on the benefit authorization form, you must ask for a new benefit authorization.

How Much Will It Cost?

You must pay part of the monthly expenses for the person's care before TRICARE Standard can help. How much you must pay depends on the sponsor's pay grade. The monthly costs are shown in the following chart.

Pay Grade	*Member Pays*
E-1 to E-5	$25
E-6	30
E-7, O-1	35
E-8, O-2	40
E-9, W-1, W-2, O-3	45
W-3, W-4, O-4	50
W-5, O-5	65
O-6	75
O-7	100
O-8	150
O-9	200
O-10	250

One Eligible Person with a Qualifying Disability

After you have paid your share, TRICARE Standard will pay as much as $1,000 a month for Program for Persons with

Disabilities benefits. If the costs are more than $1,000 in a month, you must pay the extra.

Two or More Eligible Persons with Qualifying Disabilities

If there are two or more persons with the same sponsor who qualify for the Program for Persons with Disabilities, TRICARE will make sure you won't have to pay any more than you pay for one. TRICARE Standard covers all allowable costs for the second person, as long as you pay your full monthly share for the other disabled person. Check with your HBA or TSC for more information.

You Can Appeal Certain TRICARE Decisions

If you have a factual dispute with certain decisions made by the TRICARE contractor or by the TRICARE Support Office (TSO)—formerly known as CHAMPUS headquarters, or OCHAMPUS—you have the right to appeal—to ask the TRICARE contractor or the TSO to take another look or to get another opinion on the decision.

Important Note:

The following pages describe the TRICARE appeals procedures applicable to the routine processing of TRICARE Standard claims and authorization of care. However, TRICARE managed-care contracts have been implemented throughout much of the country (TRICARE should be in operation nationwide by early 1998), and the appeals procedures that TRICARE contractors use in these areas may vary from the procedures described below. Whatever the situation, a decision which is appealable should include specific notice of your right to appeal, including the address of the next level of appeal. If you have any questions about your right to appeal after reading this handbook and the specific notice of your appeal rights included on a TRICARE Standard decision, check with your nearest Health Benefits Adviser or your TRICARE contractor for more information.

Generally, there are three possible levels of review under TRICARE Standard appeal procedures. The levels available in any particular case will be specified in the notice of your right to appeal a particular decision. The three levels include:

- Reconsideration, conducted by the TRICARE contractor responsible for the decision in a particular case;
- Formal review, conducted by a contractor or by the TSO;
- Hearing administered by the TSO, but conducted by an independent hearing officer.

When the contractor denies your initial request, there are only two levels of review: formal review and hearing, both conducted by the TSO.

What You Can't Appeal

You can't appeal what the CHAMPUS regulation or the law says. You can't appeal the amount that the TRICARE contractor determines to be the allowable charge for a particular medical service. You can't appeal the decision by TSO or by TRICARE contractors to ask you for more information before action on your claim or other request.

You may ask that the amount of the allowable charge be reviewed by the TRICARE contractor to determine if it was calculated correctly. This is called an ***allowable charge review***, not an appeal.

Decisions Relating to Eligibility and Nonavailability Statements

Although both of these issues affect your use of TRICARE Standard, you can't appeal such decisions through TRICARE. The uniformed services decide if someone is eligible for TRICARE and issue ID cards. And the military hospital decides about issuing nonavailability statements. You must appeal decisions regarding these issues through the particular service involved.

Decisions Relating to the Status of TRICARE Providers

Although a beneficiary may have an interest in receiving care or has received care from a particular provider, that beneficiary cannot appeal a decision denying the provider authorization to be a TRICARE provider or a decision which otherwise sanctions (i.e., terminates, excludes or suspends) the provider under TRICARE. The provider in question ***can*** appeal, however.

If you disagree about the facts in your case, such as whether your diagnosis was correct or whether you were required to be in the hospital, or if you think there is a mistake in how the law or regulation was interpreted, you can appeal by following the procedures spelled out below.

Reconsiderations by the TRICARE Contractors

If you disagree with a decision that comes back on the Explanation of Benefits (EOB) or some other decision by the TRICARE contractor:

- Write back to the TRICARE contractor, or to the address specified in the notice of your right to appeal, included in your EOB or other decision. Your letter must be postmarked or received by the TRICARE contractor within **90 days** of the date on the EOB or the notice with which you disagree. Be sure to include a copy of the EOB or notice, as well as any other information or papers to support your position;
- The TRICARE contractor will review the case and will issue a "reconsideration decision";
- If the amount in dispute is less than $50, the reconsideration by the TRICARE contractor is final;
- If you still disagree, and if $50 or more is in dispute, you can ask the TSO for a formal review.

Formal Review by the TRICARE Support Office

If you disagree with a reconsideration decision, or with a decision made by the TSO, and if notice of your right to appeal any decision identifies the TSO as the next level of appeal:

- Write to the TSO, making sure your letter is postmarked within **60 days** of the date on the notice or reconsideration decision with which you disagree. If you have them, be sure to include a copy of the notice as well as any other information or papers to support your position. But even if you don't have some of the supporting papers yet, send your letter in anyway, to meet the deadline requirements. Send the other documents in when you get them. Your request for a formal review should be sent to: TRICARE Support Office, Appeals, Aurora, CO 80045-6900;

- The TSO will review the case and will issue a formal review decision;
- If the amount still in dispute is less than $300, the formal review decision by the TSO is final;
- If you still disagree, and if $300 or more is still in dispute, you can ask the TSO to schedule an independent hearing.

A Hearing

When you receive the formal review decision—or any other decision which may be appealed directly to a hearing—it tells you the steps for requesting a hearing. These steps go all the way to the point that the TSO Director or the Assistant Secretary of Defense for Health Affairs makes a final decision.

A hearing is conducted by an independent hearing officer at a location convenient to both the requesting party and the government.

Be Aware

- Only the patient, the participating provider, the parent of a child under 18, the guardian of a patient who is not competent to act in his or her own behalf, or an appointed representative can appeal. For example, a military sponsor can't appeal the denial of a spouse's claim without the spouse's written consent;
- The appealing party must prove that he or she is entitled to TRICARE benefits;

- You must meet the deadlines discussed on the previous pages in this chapter. Your requests must be postmarked or received within the required deadlines. If not, the DOD regulations say the decision—the one you want to appeal—is final. If you want to submit additional information, and can't get it submitted within the filing deadline, you still must file your appeal by the deadline, but you can indicate that more information is coming;
- If your appeal concerns a decision by the TRICARE contractor, you must ask the contractor for a reconsideration before the TSO can do a formal review;
- Your appeal usually must go through a formal review by the TSO before an independent hearing can be held;
- TRICARE cannot pay for any of your costs in making an appeal;
- When part of an episode of care is cost-shared by TRICARE and part is denied, the whole episode of care will be reviewed when you appeal;
- For appeal-filing purposes, a postmark is a cancellation mark issued by the U.S. Postal Service (for persons who live overseas and who file appeals, postmarks from other countries don't count). Private mail carriers don't issue postmarks. If your letter requesting an appeal is not postmarked by the U.S. Postal Service, it will be considered filed on the date it is ***received*** by the TRICARE contractor or the TSO;
- Filing an appeal by facsimile transmission (fax) is acceptable. An appeal submitted is considered filed on the date it is received by the TRICARE contractor or the TSO.

CHAMPVA

Although very similar to TRICARE Standard in terms of benefits, it's important to note that CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs) is a separate program, distinctly different from TRICARE Standard.

CHAMPVA is the Department of Veterans Affairs' version of TRICARE Standard, in which VA shares with eligible VA beneficiaries the cost of covered health care services and supplies. Administration of CHAMPVA, including the determination of eligibility, the authorization of benefits, and the processing of claims, is the sole responsibility of the Veterans Affairs Health Administration Center in Denver, Colo. For information, contact:

Veterans Affairs Health Administration Center
300 Jackson St.
P.O. Box 65023
Denver, CO 80206-5023

Toll-free phone: 1-800-733-8387

Tips on Using TRICARE Standard

- Get to know the nearest Health Benefits Adviser (HBA) or the people at your nearest TRICARE Service Center (TSC). They're called Health Care Finders (HCFs) or Beneficiary Service Representatives (BSRs). They can help you get the most from your health benefits. Also, learn the location of your local contractor's nearest TRICARE Service Center and Health Care Finder's office. They also can provide information. (See the section in the back of the book, titled "Uniformed Services Medical Facilities," for listings of uniformed services hospitals and clinics where HBAs may be found.)
- Use uniformed services hospitals or clinics whenever possible. They save you money and paperwork.
- If you live within 40-60 air miles of a service hospital, check with the HBA there to find out if your home address falls within the hospital's ZIP code zone for health care. If so, you must try to use the service hospital first for any non-emergency inpatient civilian care. If that specific care is not available at the service hospital, you must get a nonavailability statement before using TRICARE Standard—unless you have a private health insurance policy that pays first for medical services. If that's the case, you don't need a nonavailability statement. For certain kinds of highly specialized or very expensive care, ZIP code zones

may be increased in size. Check with your HBA or TSC on this before getting care.

- Certain outpatient procedures must be authorized ahead of time for patients who live in areas where the TRICARE managed-care program is in operation. (See the chapter titled “Where to Get Care” for more information.)
- You can save money by going to a doctor or other health care provider who “participates in TRICARE Standard.” The HBA/TSC/HCF may help you find one. Or ask a provider to participate, and have the provider call the claims processor for information on the allowable charge.

  Remember:

  Providers can participate on a case-by-case basis. (See the definition of “participating provider” in the Glossary.)
- Even if a hospital participates in TRICARE Standard, sometimes the doctors and other providers who care for you there do not. If possible, check on this by phone before you go to get care.
- Check your family’s DEERS listings annually to make sure the most accurate eligibility and home-address information is included. Enroll newborn children in DEERS as soon as possible. You can do this at your nearest uniformed service facility’s personnel office. Keeping your DEERS files current helps your TRICARE contractor process claims for your family more quickly.
- When you go to get care, have your ID card with you. And discuss how and when to pay your part of the bills. If you are getting outpatient care and have already paid your

deductible for that year, bring the Explanation of Benefits (EOB) showing that.

- If you have to file your own claims, fill out claim forms carefully and neatly to speed payment. Be sure to include both your daytime and evening phone numbers. That way, the TRICARE contractor can call you if there are any problems with the form.
- Don't forget to send a copy of the medical bill and clear copies of any other papers that support the claim form.
- TRICARE Standard claims should go to the TRICARE contractor for the state (or country) in which you received care (if you live in an area where TRICARE is now operating, claims will go to the contractor who serves the area ***in which you live***). Your HBA or TSC can give you the right address and toll-free telephone number. (See the "How to File a Claim" chapter in this handbook for addresses and phone numbers.)
- You'll find it easier to reach the claims processors on the toll-free telephones during "non-peak" hours—that is, from the beginning of work hours until 9 a.m., and from 2:30 p.m. until closing, Tuesdays through Thursdays. Remember, their phones are usually open during work hours for the states where their headquarters are located. They'll also have an automated phone system operating after normal office hours which you can use to get answers to simple questions, check on claims status or request forms.
- Keep copies of all your TRICARE Standard claims and papers, even when your provider sends them in.

- To ensure prompt payment, TRICARE Standard claims should be filed soon after the care is received. Claims must arrive at the contractor's processing office within one year of the date on which you get care—or, for inpatient care, one year from your date of discharge from an inpatient facility.
- If your contractor asks you for more information on a claim, be sure to respond within 35 days of the request. Otherwise, the claim may be denied. Be sure your sponsor's Social Security Number is on the response, and include a copy of the letter requesting the information.
- Families, including active-duty, who use TRICARE Standard often should consider supplemental insurance to cover the cost-share under TRICARE Standard. Your HBA or TSC can direct you to the military associations or companies that offer supplemental insurance.
- TRICARE Standard coverage and cost-share terms may be changed by Congress.

For Retirees and Survivors

- Remember, if you're eligible for Medicare (Part A)—either on your own or through your spouse or parent—you aren't covered by TRICARE unless you're under age 65 and Medicare-eligible because you're disabled or you have end-stage kidney disease—*and*, you're enrolled in Medicare Part B. (See the note under "Medicare and TRICARE" in the "Who's Covered?" section.)
- If you're 65 and not eligible for Medicare Part A, you must get a "Disallowance Notice" from Social Security. You

should send this in with the first claim you submit after the beginning of the month in which your 65th birthday occurs. Make sure your ID card reflects TRICARE eligibility and that DEERS is updated.

- If you're covered by Medicare, remember that Medicare doesn't cover you outside the U.S.; and because you're eligible for Medicare, TRICARE can't cover you. (Exception: Persons under age 65 who are Medicare-eligible because of disability or end-stage kidney disease and who purchase Medicare Part B.) If you'll be outside the U.S., you may want to consider private health insurance.
- You're not covered by the TRICARE Program for Persons with Disabilities. But the survivors of deceased active-duty sponsors are covered for the first year after the sponsor's death.
- Because your cost-share is more, it makes even more sense for you to:
  - Use a uniformed services hospital or clinic whenever possible, and
  - Get TRICARE supplemental insurance from a military association or a private company, or buy a "primary" health insurance policy—one which pays before TRICARE does—for your covered health care.

If You Suspect Fraud

If something doesn't seem right about your medical bills—perhaps the same item is billed twice, or you've been billed for services you never received—here's what to do:

1. Double-check the billings from your provider of care and the Explanation of Benefits (EOB) you received from your TRICARE contractor. Be sure that the only services listed are ones you actually received.

2. If you can't resolve any problems you find by talking to the provider's billing office (some discrepancies might simply be the result of errors in billing), write to the program integrity unit of your regional TRICARE contractor. Explain what you think the problem is, and include copies of the EOB and any other relevant documents.

3. If you know, or have evidence of, another individual—whether it be a provider of care or a TRICARE-eligible person—submitting fraudulent claims to TRICARE, write to your contractor.

4. Although cost-shares under TRICARE may vary, it's illegal for a provider to waive those cost-shares. When a cost-share is waived, it may keep you from seeking a much-needed second opinion. Here's an example: *A woman is diagnosed with a terminal disease. Her physician waived her cost-share (the portion of the medical bills she was supposed to pay), and the woman didn't seek a second opinion because she didn't want to pay a share of the second physician's charges. Months later, she found out that she wasn't terminally ill after all. A second opinion could have saved her months of unnecessary worry*. You and TRICARE are partners in the payment of your medical expenses. Report to your regional TRICARE contractor any provider who waives your cost-share.

Millions of tax dollars are lost to fraud and abuse of your health benefits programs each year. Your vigilance and alertness may be able to help bring perpetrators of health care fraud and abuse to justice.

TRICARE Active-Duty Family Member Dental Plan

The Defense Department's TRICARE Active-Duty Family Member Dental Plan offers basic preventive and restorative dental care to the enrolled families of active-duty sponsors in the seven uniformed services. The care is provided by civilian dentists. Claims are filed, either by the dentists or by the families who received the dental care, with the civilian contractor who operates the dental plan for the services.

The plan covers persons living in the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands and Canada.

The TRICARE Active-Duty Family Member Dental Plan is not a TRICARE program. It has nothing to do with any medical care-related dental treatment that may be provided to TRICARE-eligible persons under the TRICARE Standard basic program.

For more information about the TRICARE Active-Duty Family Member Dental Plan, contact your nearest military personnel office for questions about enrollment. For questions about benefits and the dental plan, contact your military personnel office or your nearest Health Benefits Adviser. Or, call or write the civilian contractor as indicated below:

Claims Mailing Address

United Concordia Companies, Inc.
FMDP Claims Processing
P.O. Box 989220
Camp Hill, PA 17089-8220

Information/Inquiries

United Concordia Companies, Inc.
Customer Service
P.O. Box 89218
Camp Hill, PA 17089-8218

Toll-free telephone: 1-800-866-8499

To get TRICARE Active-Duty Family Member Dental Plan claim forms, contact your Health Benefits Adviser or United Concordia.

Glossary

Accept TRICARE Standard assignment

See “Participate in TRICARE.”

Allowable charge

The amount on which TRICARE Standard figures your cost-share for covered care. TRICARE Standard figures the allowable charge from all professional (non-institutional) providers’ bills nationwide, with adjustments for specific localities, over the last year. The claims processor can tell a provider the allowable charge amount for specific services or procedures. Also known as the “CHAMPUS Maximum Allowable Charge” (CMAC).

Authorized provider

A doctor or other individual authorized provider of care, hospital or supplier who has applied to, and been approved by, TRICARE to provide medical care and supplies. Generally, that means the provider is licensed by the state, accredited by a national organization, or meets other standards of the medical community. If a provider is not authorized, TRICARE cannot help pay the bills. (See the “Where to Get Care” chapter for other providers.)

Balance billing

This is when a provider bills you for the rest of his or her charges (the “balance” of the charges), after your civilian health insurance plan or TRICARE has paid everything it’s

going to pay. Federal law says you aren't legally responsible for amounts in excess of 15 percent above the TRICARE allowable charge.

Capitation

A fixed amount of money that a managed-care plan gives to a doctor or hospital to care for a patient, no matter what the patient's care actually costs.

Catastrophic cap

A cost "cap" or upper limit has been placed on TRICARE Standard-covered medical bills in any fiscal year. The limit that an active-duty family will have to pay is $1,000; the limit for all other TRICARE Standard-eligible families is $7,500. (See the beginning of the "How Much Will It Cost?" chapter for more details about this cap on your medical expenses and for the limitations that apply.)

Claims processor

That's the contractor that handles the TRICARE claims for care received within a particular state or region. They're also called TRICARE contractors and "fiscal intermediaries" or FIs. They have toll-free phone numbers to handle your questions.

Co-payment

This is a fixed amount you'll pay when you're enrolled in TRICARE Prime and you visit the doctor for some type of medical care. Sometimes, the terms "co-payment" and "cost-share" (see below) are used interchangeably.

Cost-share

That's the percentage you pay—and the part TRICARE Standard pays—of the allowable charges for care on each claim. Your cost-share depends on your sponsor's status

(active or retired) in the service. Your cost-share is paid in addition to the annual deductible for outpatient care and anything a non-participating provider charges above the allowable charge. The TRICARE Standard cost-share is the difference between the allowable charge and your cost-share.

Deductible

That's the amount you must pay on your bills each year toward your outpatient medical care, before TRICARE begins sharing the cost of medical care. That is, you pay your provider(s) the first $150 for an individual, or $300 for a family, worth of medical bills each fiscal year—from October 1 through September 30 (for the families of active duty members in pay grade E-4 and below, the deductible amounts are $50 for an individual and $100 for a family). The contractor keeps track of your deductible and subtracts it from your claims during the year. How much you've paid toward your deductible is spelled out on the Explanation of Benefits. The deductible is separate from, and in addition to, your cost-share.

DEERS

The Defense Enrollment Eligibility Reporting System. That's the computerized data bank which lists all active and retired military members, and should also include their dependents. Active and retired service members are listed automatically, but they must take action to list their dependents and report any changes to family members' status (marriage, divorce, birth of a child, adoption, etc.), and any changes to mailing addresses. TRICARE contractors check DEERS before processing claims to make sure patients are eligible for TRICARE benefits.

Diagnosis-Related Groups (DRGs)

DRGs are a way of paying civilian hospitals for inpatient care under TRICARE Standard. They're effective in 48 states, the District of Columbia and Puerto Rico. Only Maryland and New Jersey are exempt from the federal DRG payment system. Under DRGs, TRICARE Standard pays most hospitals a fixed rate for inpatient services, regardless of how much the care actually costs. The goal is to cut health care costs for both military families and the government. (See the "Inpatient Costs" section in the "How Much Will It Cost?" chapter for a more detailed explanation of DRGs.)

Explanation of Benefits (EOB)

A statement the TRICARE contractor sends you and the provider who participates in TRICARE Standard that shows who provided the care, the kind of covered service or supply received, the allowable charge and amount billed, the amount TRICARE Standard paid, how much of your deductible's been paid, and your cost-share. It also gives the reason for denying a claim. Sometimes also called the TRICARE Explanation of Benefits (TEOB).

Extra

See "TRICARE Extra."

Fiscal Intermediary (FI)

See "claims processor."

Health Benefits Adviser (HBA)

Persons at military hospitals or clinics who are there to help you get the medical care you need through the military and through TRICARE. Contact an HBA whenever you have any questions on obtaining medical care. But remember—

while HBAs can give valuable advice and assistance, they can't guarantee coverage under TRICARE. Your TRICARE contractor must review each claim and make payment determinations in accordance with uniformed services eligibility rules and the TRICARE Standard regulation.

Health Care Finder (HCF)

These are health care professionals, generally registered nurses, who help you find needed care. They work with your Primary Care Manager (PCM) to locate the specialty care you may require. Health Care Finders are located at TRICARE Service Centers.

Health Maintenance Organization (HMO)

A health plan to which you pay a fixed premium (and often, small user fees) for an assortment of medical services, usually including primary and preventive care. The HMO employs physicians, therapists, etc., to serve your medical needs.

Managed care

A concept under which an organization (like an HMO) delivers health care to enrolled members and controls costs by closely supervising and reviewing the delivery of care.

Medically (or psychologically) necessary

Medical (or psychological) services or supplies which are considered appropriate care and are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, mental disorders, or well-child care.

Military hospitals

We use it as shorthand for all uniformed service hospitals including the ten former Public Health Service hospitals. Also, the acronym "MTF" (military treatment facility) is sometimes used to refer to military hospitals. (See "Uniformed services hospitals.")

Nonavailability statement (NAS)

That's a certification from the uniformed service hospital that says it can't provide the care you need. If you live in certain ZIP codes around a military hospital, you must get a nonavailability statement before getting non-emergency ***inpatient*** care at a civilian hospital under TRICARE Standard. Don't forget—TRICARE does not determine eligibility, nor does it issue nonavailability statements. The statements must be entered electronically in the Defense Department's DEERS computer files by your nearby military medical facility. (See the "Nonavailability Statements" section of the "Where to Get Care" chapter for the exceptions to this rule.)

Other health insurance

If you have other health care coverage—besides TRICARE Standard or TRICARE Extra or Prime—for yourself and your family through an employer, an association or a private insurer; or if a student in the family has a health care plan obtained through his or her school—that's what TRICARE considers "other health insurance" (OHI). It may also be called "double coverage" or "coordination of benefits." It doesn't include TRICARE supplemental insurance. It also does not include Medicaid. (See the definition of TRICARE supplemental insurance later in this glossary.)

Participate in TRICARE

Health care providers who "participate" in TRICARE, also called "accepting assignment," agree to accept the TRICARE allowable charge (including your cost-share and deductible, if any) as the full fee for your care. Individual providers can participate on a case-by-case basis. They file the claim for you and receive the check, if any, from TRICARE. Hospitals that participate in Medicare must, by law, also participate in TRICARE Standard for inpatient care. For outpatient care, hospitals may or may not participate.

Participating provider

See "Participate in TRICARE."

Preferred Provider Organization (PPO)

A network of health care providers who provide services to patients at discounted rates or cost-shares.

Prime

See "TRICARE Prime."

Provider

A doctor, hospital or other person or place that delivers medical services and/or supplies.

Sponsor

The service person—either active-duty, retired or deceased, whose relationship to you (spouse, parent, etc.) makes you eligible for TRICARE.

TRICARE Prime

One of the three health care options under DOD's TRICARE managed health care program for military families. TRICARE Prime is the HMO-type option, under

which you enroll for a year at a time, and agree to seek health care from the network of health care providers and institutions set up by the TRICARE contractor for the region in which you live. (See the "TRICARE Prime" section at the beginning of this book for more details about Prime, such as how this option works and how much it costs.)

TRICARE Extra

This is the second of the three health care options under DOD's TRICARE managed health care program. You don't have to enroll in Extra; you may use it on a case-by-case basis. You simply see a provider who's part of the TRICARE Extra network established by the local TRICARE contractor, and pay reduced cost-shares for your care. (See the "TRICARE Extra" section at the front of this book for more details about Extra.)

TRICARE Standard supplemental insurance

These are health benefit plans that are specifically designed to supplement TRICARE Standard benefits. They generally pay most or all of whatever's left after TRICARE Standard has paid its share of the cost of covered health care services and supplies. These plans are frequently available from military associations and other private organizations and firms. Such policies aren't necessarily just for retirees, but may be useful for other TRICARE-eligible families as well.

Uniformed services hospitals

This includes all military hospitals and former Public Health Service hospitals that are now called "uniformed services treatment facilities" (USTFs) in Baltimore; Boston; Seattle; Portland, Maine; Cleveland; Houston,

Galveston, Port Arthur and Nassau Bay, Texas; and Staten Island, N.Y.

Uniformed Services Medical Facilities

Note: Because of the various base closings and realignments currently underway or planned, some hospitals may be closed or changed to clinics after this handbook is published. The following list of medical facilities is as complete and accurate as was possible at press time. States or countries that aren't listed have no military medical or dental facilities.

ALABAMA

Medical Clinics:

Fox Army Community Clinic, Redstone Arsenal, AL 35809-7000

Lyster Army Community Clinic, Fort Rucker, AL 36362-5350

42 Medical Group, Maxwell AFB, AL 36112-6219

US Army Health Clinic, Anniston Army Depot, Anniston, AL 36205-5083

US Coast Guard Aviation Training Center Clinic, Mobile, AL 36608

ALASKA

Hospitals:

Bassett Army Community Hospital, Fort J. M. Wainwright
Fairbanks, AK 99703-7300

3 Medical Group, Elmendorf AFB, AK 99506-3700

Medical Clinics:

US Army Health Clinic, Fort Greely, Big Delta, AK 96508
(Scheduled to close 9/30/97)

US Army Troop Medical Clinic, Fort Richardson, Anchorage,
AK 99505

354 Medical Group, Eielson AFB, AK 99702-2325

US Coast Guard Base Clinic, Ketchikan, AK 99901

US Coast Guard Support Center, Health Services Clinic,
Kodiak, AK 99619

US Coast Guard Air Station Clinic, Sitka, AK 99835

ARIZONA

Hospitals:

Raymond W. Bliss Army Community Hospital, Ft. Huachuca,
Sierra Vista, AZ 85613-7040

56 Medical Group, Luke AFB, AZ 85309-1525

Medical Clinics:

355 Medical Group, Davis-Monthan AFB, AZ 85707-4405

US Army Health Clinic, Yuma Proving Ground, Yuma, AZ 85365

Naval Branch Medical Clinic, Marine Corps Air Station, Yuma, AZ 85369-5008

ARKANSAS

Medical Clinics:

314 Medical Group, Little Rock AFB, AR 72099-5057

US Army Health Clinic, Pine Bluff Arsenal, Pine Bluff (Mailing address: Reynolds Army Community Hospital, Fort Sill, Lawton, OK 73503-6400)

US Army Troop Medical Clinic, Fort Chaffee, Fort Smith (Mailing address: Reynolds Army Community Hospital Fort Sill, Lawton, OK 73503-6400)

CALIFORNIA

Hospitals:

60 Medical Group, Travis AFB, CA 94535-1880

95 Medical Group, Edwards AFB, CA 93523-1730

30 Medical Group, Vandenberg AFB, CA 93437-5300

Weed Army Community Hospital, Fort Irwin, CA 92310-5065

Naval Hospital, Lemoore, CA 93246-5004

Naval Hospital, San Diego, CA 92134-5000

Naval Hospital, Camp Pendleton, CA 92055-5008

MCAGCC Twenty-Nine Palms, CA 92278-5008

Medical Clinics:

Oakland Army Base, Oakland 94626

Sierra Army Depot, Herlong 96113

Fort Hunter Liggett, Jolon (Army) 93928

Presidio of Monterey, Monterey (Army) 93940

9 Medical Group, Beale AFB, CA 95903-1907

61 Medical Group, Los Angeles AFB, CA 90245-4661

77 Medical Group, Mather AFB, CA 95655-1200

77 Medical Group, McClellan AFB, CA 95652-1074

750 Medical Squadron, Sunnyvale, CA 94089-1234

US Coast Guard Support Center Clinic, Coast Guard Island, Alameda, CA 94501

US Coast Guard Training Center Clinic, Petaluma, CA 94952

US Coast Guard Support Center Clinic, San Pedro, CA 90731-0208

Port Hueneme, CA 93043-5004 (Navy)

NAVSTA, San Diego, CA 92136-5153

MCLB Barstow, CA 92311 (Navy/Marine)

MCMWTC Bridgeport, CA 93517 (Navy/Marine)

Headquarters, Area 13, Camp Pendleton, CA 92055 (Navy)

Del Mar, Area 21, Camp Pendleton, CA 92055 (Navy)

Chappo, Area 22, Camp Pendleton, CA 92055 (Navy)

Base Correctional Fac, Area 24, Camp Pendleton, CA 92055 (Navy)

Edson Range, Area 31, Camp Pendleton, CA 92055 (Navy)

Margarita, Area 33, Camp Pendleton, CA 92055 (Navy)

Las Flores, Area 41, Camp Pendleton, CA 92055 (Navy)

Las Pulgas, Area 43, Camp Pendleton, CA 92055 (Navy)

San Onofre, Area 52, Camp Pendleton, CA 92055 (Navy)

Horno, Area 53, Camp Pendleton, CA 92055 (Navy)

San Mateo, Area 62, Camp Pendleton, CA 92055 (Navy)

NWS, Area 65, Camp Pendleton, CA 92055 (Navy)

NWC China Lake, CA 93555 (Navy)

WPNSTA Seal Beach, CA 90740 (Navy)

NAVSTA Coronado, CA 91720-5000

NAVSTA San Diego, CA 92136-5133

NSC San Diego, CA 92132 (Navy)

MCRD San Diego, CA 92140 (Navy/Marine)

NAF El Centro, CA 92243 (Navy)

NAS Miramar, CA 92145

NAVPHIBASE Coronado, CA 92155-5046

NTC San Diego, CA 92133-5000 (Navy)

NAS North Island, CA 92135-5103

NALF San Clemente, CA 92135

NAS Point Mugu, CA 93042

NAVSTA Treasure Island, CA 94130-5030

NAS Alameda, CA 94501

WPNSTA Concord, CA 94520 (Navy)

NAVCOMMSTA Stockton, CA 92503

NAVFAC Pt. Sur, CA 93920

NAVFAC Centerville Beach, Ferndale, CA 95536

NAVMEDADMINU, Monterey, CA 93943

NALF Crows Landing CA 95313

COLORADO

Hospitals:

US Army Community Hospital, Fort Carson, CO 80913-5000

10 Medical Group, USAF Academy, CO 80840-4000

Medical Clinics:

21 Medical Group, Peterson AFB, CO 80914-1540

CONNECTICUT

Medical Clinics:

Naval Clinic, Groton, CT 06340-5600

NAVSUBASE New London, Groton, CT 06340-5600

NAVUPWRITRAU, Windsor Locks, CT 06095

US Coast Guard Academy Health Services Clinic, New London, Groton, CT 06320

DELAWARE

Medical Clinic:

436 Medical Group, Dover AFB, DE 19902-7307

DISTRICT OF COLUMBIA

Hospital:

Walter Reed Army Medical Center, Washington, DC 20307-5000

Medical Clinics:

US Army Health Clinic, Fort McNair, Washington, DC 20319

11 Medical Group, Bolling AFB, DC 20332-0701

US Coast Guard Clinic, Headquarters, 400 7th Street, SW, Washington, DC 20024

Arlington Annex, Federal Office Bldg. No. 2, Room 1319, Washington, DC 20370 (Navy)

NAF, Washington, DC 20396-5135

NAVSECSTA, Washington, DC 20390

Naval Research Laboratory, Washington, DC 20375

Navy Yard, Washington, DC 20374-1832

FLORIDA

Hospitals:

96 Medical Group, Eglin AFB, FL 32542-1282

6 Medical Group, MacDill AFB, FL 33621-1607

325 Medical Group, Tyndall AFB, FL 32403-5612

Naval Hospital, Pensacola, FL 32512-5300

Naval Hospital, Jacksonville, FL 32214-5600

Medical Clinics:

16 Medical Group, Hurlburt Field, FL 32544-5000

45 Medical Group, Patrick AFB, FL 32925-3606

US Coast Guard Air Station Clinic, Clearwater, FL 33520

US Coast Guard Air Station Clinic, Opa Locka Airport, Hangar 103, Opa Locka, FL 33054

US Coast Guard Health Services Clinic, Miami Beach, FL 33139-5101

Naval Medical Clinic, Key West, FL 33040-4595

NAS Jacksonville, FL 32212

NAS Cecil Field, FL 32212

NAS Key West, FL 33040

NAVSTA Mayport, FL 32228-0148

NAS Pensacola, FL 32508

NAS Whiting Field, Milton, FL 32570

NATECHTRACEN Pensacola, FL 32511

NAVCOASTSYSCEN, Panama City, FL 32407

GEORGIA

Hospitals:

Dwight David Eisenhower Army Medical Center, Fort Gordon, GA 30905-5060

Martin Army Community Hospital, Fort Benning, GA 31905-6006

Winn Army Community Hospital, Fort Stewart, GA 31314-5300

347 Medical Group, Moody AFB, GA 31699-1500

Medical Clinics:

78 Medical Group, Robins AFB, GA 31098-2227

Tuttle Army Health Clinic, Hunter Army Field, Savannah, GA 31409 (Mailing address: Winn Army Community Hospital, Fort Stewart, GA 31314-5300)

US Army Health Clinic, Fort McPherson, Atlanta, GA 30330-5000 (Mailing address: Dwight David Eisenhower Army Medical Center, Fort Gordon, GA 30905-5060)

US Army Health Clinic, Fort Gillem, Forest Park (Mailing address: Dwight David Eisenhower Army Medical Center, Fort Gordon, GA 30905-5060)

US Army Troop Medical Clinic, Dahlonega (Mailing address: Martin Army Community Hospital, Fort Benning, GA 31905-6006)

Naval Medical Clinic, MCLB, Albany, GA 31705

NSCS Athens, GA 30606 (Navy)

NAS Atlanta, Marietta, GA 30060-5099

NSB Kings Bay, GA 31547 (Navy)

HAWAII

Hospitals:

Tripler Army Medical Center, HI 96859-5000

Medical Clinics:

NAVSHIPYD Pearl Harbor, Oahu, HI 96860

NAVMAG Lualualei, Oahu, HI 96792

NAVCAMS Eastpac, Honolulu, Wahiawa, Oahu, HI 96786

MCAS Kaneohe Bay, Oahu, HI 96863 (Marine)

Westloch, Pearl Harbor, Oahu, HI 96860 (Navy)

Mental Health, Pearl Harbor, Oahu, HI 96860 (Navy)

US Army Health Clinic, Schofield Barracks, Honolulu, Oahu (Mailing address: Tripler Army Medical Center, HI 96859-5000)

US Army Troop Medical Clinic, Pohakuloa Training Area, Hilo, Hawaii (Mailing address: Tripler Army Medical Center HI 96859-5000)

US Army Troop Medical Clinic, Kilauea Military Camp, Kilauea, Kauai (Mailing address: Tripler Army Medical Center, HI 96859-5000)

15 Medical Group, Hickam AFB, HI 96853-5399

US Coast Guard Base Clinic, Honolulu, HI 96819

Naval Medical Clinic, Pearl Harbor, Oahu, HI 96860-5058

Naval Branch Medical Clinic, NAS Barbers Point, Oahu, HI 96862

IDAHO

Hospital:

366 Medical Group, Mountain Home AFB, ID 83648-5300

ILLINOIS

Hospitals:

375 Medical Group, Scott AFB, IL 62225-5252

Naval Hospital, Great Lakes, IL 60088-5230

Medical Clinics:

Rock Island Arsenal, Rock Island, IL 61299 (Mailing address: General Leonard Wood Army Community Hospital, Fort Leonard Wood, MO 65473-5700)

NTC Great Lakes, IL 60088 (Navy)

RTC Great Lakes, IL 60088 (Navy)

KANSAS

Hospitals:

Irwin Army Community Hospital, Fort Riley, KS 66442-5036

22 Medical Group, McConnell AFB, KS 67221-3506

Medical Clinic:

Munson Army Community Clinic, Fort Leavenworth, KS 66027-5400

KENTUCKY

Hospitals:

Blanchfield Army Community Hospital, Fort Campbell, KY 42223-1498

Ireland Army Community Hospital, Fort Knox, KY 40121-5520

Medical Clinics:

Blue Grass Army Depot, Lexington (Mailing address: Ireland Army Community Hospital, Fort Knox, KY 40121-5520)

Blue Grass Depot Activity, Richmond (Mailing address: Ireland Army Community Hospital, Fort Knox, KY 40141-5520)

LOUISIANA

Hospitals:

Bayne-Jones Army Community Hospital, Fort Polk, LA 71459-6000

2 Medical Group, Barksdale AFB, LA 71110-2425

Medical Clinics:

US Coast Guard Base Clinic, 4640 Urquhart St., New Orleans, LA 70117

Naval Medical Clinic, New Orleans, LA 70142-5300

MAINE

Hospital:

Uniformed Services Medical Treatment Facility, Coastal Health Services, 331 Veranda St., Portland, ME 04103

Medical Clinics:

NAS Brunswick, ME 04011-5000

NSGA Winter Harbor, ME 04693 (Navy)

NAVCOMMU Cutler, E. Machias, ME 04630

MARYLAND

Hospitals:

89 Medical Group, Andrews AFB, MD 20762-6600

Uniformed Services Medical Treatment Facility, Wyman Park Health System, Inc., 3100 Wyman Park Drive, Baltimore, MD 21211

Naval Hospital, Bethesda, MD 20889-5000

Medical Clinics:

Naval Clinic, Patuxent River, MD 20670-5370

Kimbrough Army Community Clinic, Fort Meade, Odenton, MD 20755-5000

Edgewood Area, Aberdeen Proving Ground, MD (Mailing address: Kimbrough Army Community Clinic, Fort Meade, Odenton, MD 20755-5000)

Fort Detrick, Frederick, MD (Mailing address: Kimbrough Army Community Clinic, Fort Meade, Odenton, MD 20755-5000)

Kirk Army Health Clinic, Aberdeen Proving Ground (Mailing address: Kimbrough Army Community Clinic, Fort Meade, Odenton, MD 20755-5000)

US Coast Guard Yard Clinic, Curtis Bay, Baltimore, MD 21226

Naval Medical Clinic, Annapolis, MD 21402-5050

NSRDC Carderock, Bethesda, MD 20084 (Navy)

NAF Andrews AFB, MD 20331-5300 (Navy)

USNA Bancroft Hall, Annapolis, MD 21402

NAVORDSTA Indian Head, MD 20640

NAVSWC White Oak, Silver Spring, MD 20910

MASSACHUSETTS

Hospital:

Uniformed Services Medical Treatment Facility, Brighton Marine Public Health Center, 77 Warren St., Boston, MA 02135

Medical Clinics:

US Coast Guard Air Station, Cape Cod Clinic Otis AFB, Falmouth, MA 02542

US Coast Guard Support Center Clinic, 427 Commercial St., Boston, MA 02188

66 Medical Group, Hanscom AFB, MA 01731-2139

MICHIGAN

Medical Clinics:

US Army Health Clinic, Selfridge Air National Guard Base, Mt. Clemens (Mailing address: General Leonard Wood Army Community Hospital, Fort Leonard Wood, MO 65473-5700)

US Coast Guard Air Station Clinic, Traverse City, MI 49684

MISSISSIPPI

Hospitals:

81 Medical Group, Keesler AFB, MS 39534-2519

Naval Branch Hospital, Naval Home Gulfport, MS 39501-1793

Medical Clinics:

14 Medical Group, Columbus AFB, MS 39701-5300

CBC Gulfport, MS 39501 (Navy)

NAS Meridian, MS 39309-5400

Bay St. Louis, MS 39522 (Navy)

SUPSHIP Pascagoula, MS 39567 (Navy)

MISSOURI

Hospitals:

General Wood Army Community Hospital, Fort Leonard Wood, MO 65473-5700

509 Medical Group, Whiteman AFB, MO 65305-5001

Medical Clinic:

US Army Health Clinic, 1520 Market Street, St. Louis, MO 63103

MONTANA

Medical Clinic:

341 Medical Group, Malmstrom AFB, MT 59402-6780

NEBRASKA

Hospital:

55 Medical Group, Offutt AFB, NE 68113-2160

NEVADA

Hospital:

99 MDG, Nellis Federal Hospital, Las Vegas, NV 89191-6001

Medical Clinic:

Naval Branch Medical Clinic, Fallon, NV 89406-5000

NEW HAMPSHIRE

Medical Clinic:

Naval Medical Clinic, Portsmouth, NH 03801-5000

NEW JERSEY

Hospitals:

Patterson Army Community Hospital, Fort Monmouth, NJ 07703-5504

305 Medical Group, Fort Dix AIN, NJ 08640-5047

Medical Clinics:

Picatinny Arsenal, Dover (Mailing address: Patterson Army Community Hospital Fort Monmouth, NJ 07703-5504)

US Coast Guard Training Center Clinic, Cape May, NJ 08204

NAVAIRPROCEN Trenton, NJ 08628

WPNSTA Earle, Colts Neck, NJ 07722 (Navy)

NAVAIRENGCEN Lakehurst, NJ 08733-5066

NEW MEXICO

Hospitals:

27 Medical Group, Cannon AFB, NM 88103-5014

377 Medical Group, Kirtland AFB, NM 87117-5559

49 Medical Group, Holloman AFB, NM 88330-8273

Medical Clinic:

McAfee Army Health Clinic, White Sands Missile Range, Las Cruces (Mailing address: William Beaumont Army Medical Center, El Paso, TX 79920-5001)

NEW YORK

Hospitals:

William L. Keller Army Community Hospital, West Point, NY 10996-1190

Uniformed Services Medical Treatment Facility, Bayley-Seton Hospital, Bay St. and Vanderbilt Ave., Staten Island, NY 10304

Medical Clinics:

Ainsworth Army Health Clinic, Fort Hamilton, Brooklyn (Mailing address: Patterson Army Community Hospital, Fort Monmouth, NJ 07703-5504)

Seneca Army Depot, Romulus 14541

Watertown Arsenal, Watertown (Ft. Drum) 13602

Watervliet Arsenal, Watervliet (Mailing address: Cutler Army Community Hospital Fort Devens, MA 01433)

Stewart Subpost, Newburgh, NY 12550 (Army)

Fort Drum, Watertown, NY 13602-5004 (Army)

NAVUPWRTRAU, Ballston Spa, NY 12020

NAVSTA, Brooklyn, NY 11251

VA Extended Care Center, St. Albans, NY 11412

NORTH CAROLINA

Hospitals:

Womack Army Community Hospital, Fort Bragg, NC 28307-5000

Naval Hospital, Camp Lejeune, NC 28542-5008

Naval Hospital, Cherry Point, NC 28533-5008

Medical Clinics:

4 Medical Group, Seymour Johnson AFB, NC 27531-2311

23 Medical Group, Pope AFB, NC 28302-2383

US Coast Guard Support Center Clinic, Elizabeth City, NC 27909

Correctional Facility, Camp Lejeune, NC 28542 (Navy/Marine)

Camp Geiger, Camp Lejeune, NC 28542 (Navy/Marine)

Rifle Range, Camp Lejeune, NC 28542 (Navy/Marine)

Camp Johnson, Camp Lejeune, NC 28542 (Navy/Marine)

French Creek, Camp Lejeune, NC 28542 (Navy/Marine)

River Road, Camp Lejeune, NC 28542 (Navy/Marine)

Physical Exam Center, Camp Lejeune, NC 28542 (Navy/Marine)

MCAS New River, Jacksonville, NC 28545 (Navy/Marine)

NORTH DAKOTA

Hospitals:

5 Medical Group, Minot AFB, ND 58705-5024

319 Medical Group, Grand Forks AFB, ND 58205-6332

OHIO

Hospitals:

74 Medical Group, Wright-Patterson AFB, OH 45433-5529

Uniformed Services Medical Treatment Facility, Lutheran Medical Center, 2609 Franklin Blvd., Cleveland, OH 44113

Medical Clinics:

US Army Health Clinic Defense Construction Supply Center, Columbus (Mailing address: Ireland Army Community Hospital, Fort Knox, KY 40121-5520)

Naval Branch Medical Clinic, Defense Finance Center, 1240 E. 9th St., Cleveland, OH 44199-2055

OKLAHOMA

Hospitals:

Reynolds Army Community Hospital, Fort Sill, Lawton, OK 73503-6400

97 Medical Group, Altus AFB, OK 73523-5005

72 Medical Group, Tinker AFB, OK 73145-8102

Medical Clinics:

71 Medical Squadron, Vance AFB, OK 73705-5105

US Army Health Clinic, McAlester Army Ammunition Plant McAlester, OK 74501

OREGON

Medical Clinics:

US Army Health Clinic, Umatilla Army Depot, Hermiston (Mailing address: Madigan Army Medical Center, Tacoma WA 98431-5021)

US Coast Guard Air Station Clinic, North Bend, OR 97459

US Coast Guard Air Station, Astoria Clinic, Warrenton, OR 97146

PENNSYLVANIA

Medical Clinics:

Dunham Army Health Clinic, Carlisle Barracks, Carlisle (Mailing address: Kimbrough Army Community Hospital, Fort Meade, Odenton, MD 20755-5000)

Fort Indiantown Gap, Annville (Mailing address: Kimbrough Army Community Hospital, Fort Meade, Odenton, MD 20755-5000)

New Cumberland Army Depot, New Cumberland (Mailing address: Kimbrough Army Community Hospital, Fort Meade, Odenton, MD 20755-5000)

Letterkenny Army Depot (Mailing address: Kimbrough Army Community Hospital, Fort Meade, Odenton, MD 20755-5000)

Defense Personnel Support Center, Philadelphia (Mailing address: Walson Army Community Hospital, Fort Dix, NJ 08640-6600)

Tobyhanna Army Depot, Tobyhanna, PA 18466

NAVAIRDEVCEN, Warminster, PA 18974

NAS Willow Grove, PA 19090

SPCC Mechanicsburg, PA 17055 (Navy)

RHODE ISLAND

Hospital:

Naval Hospital, Newport, RI 02841-5003

Medical Clinic:

Naval Branch Medical Clinic, CBC Davisville, RI 02854

SOUTH CAROLINA

Hospitals:

Moncrief Army Community Hospital, Fort Jackson, Columbia, SC 29207-5780

20 Medical Group, Shaw AFB, SC 29152-5019

Naval Hospital, Charleston, SC 29408-6900

Naval Hospital, Beaufort, SC 29902-6148

Medical Clinics:

437 Medical Group, Charleston AFB, SC 29404-4704

WPNSTA Charleston, SC 29408 (Navy)

NAVSTA Charleston, SC 29408

NAVSHIPYD Charleston, SC 29408

MCRD Parris Island, SC 29905 (Navy/Marine)

MCAS Beaufort, SC 29902 (Navy/Marine)

SOUTH DAKOTA

Hospital:

28 Medical Group, Ellsworth AFB, SD 57706-4821

TENNESSEE

Medical Clinics:

Naval Clinic, Millington, TN 38054-5201

Naval Branch Medical Clinic, NSA Memphis, TN 38054

TEXAS

Hospitals:

William Beaumont Army Medical Center, El Paso, TX 79920-5001

Brooke Army Medical Center, Fort Sam Houston, TX 78234-6200

Darnall Army Community Hospital, Fort Hood, TX 76544-5063

59 Medical Wing, Lackland AFB, TX 78236-5300

82 Medical Group, Sheppard AFB, TX 76311-3478

7 Medical Group, Dyess AFB, TX 79607-1367

47 Medical Group, Laughlin AFB, TX 78843-5244

Uniformed Services Medical Treatment Facility, Hospital of St. John, 2050 Space Park Drive, Nassau Bay, TX 77058

Uniformed Services Medical Treatment Facilities:

St. Mary's Hospital, 404 8th Street, N. Galveston, TX 77550

St. Mary's Hospital Family Practice Center of Port Arthur, 3600 Gates Blvd., Port Arthur, TX 77640

St. Joseph Ambulatory Care Center, 1919 La Branch, Houston, TX 77002

Medical Clinics:

Naval Clinic, Corpus Christi, TX 78419-5200

US Army Health Clinic, Red River Army Depot, Texarkana (Mailing address: Darnall Army Community Hospital Fort Hood, TX 76544-5063)

70 Medical Squadron, Brooks AFB, TX 78235-5336

17 Medical Group, Goodfellow AFB, TX 76908-4902

76 Medical Group, Kelly AFB, TX 78241-5846

12 Medical Group, Randolph AFB, TX 78150-4801

NAS Kingsville, TX 78364

NAS Dallas, TX 75211-9516

UTAH

Hospital:

75 Medical Group, Hill AFB, UT 84056-5012

Medical Clinics:

Dugway Proving Ground, Dugway (Mailing address: Fort Carson, CO 80913)

Tooele Army Depot, Tooele (Mailing address: Fort Carson, CO 80913)

VIRGINIA

Hospitals:

1 Medical Group, Langley AFB, VA 23665-2080

Dewitt Army Hospital, Fort Belvoir, VA 22060-5166

McDonald Army Community Hospital, Fort Eustis, VA 23604-5567

Naval Medical Center, Portsmouth, VA 23708-5000

Medical Clinics:

Andrew Rader US Army Health Clinic, Fort Myer, VA 22211

Arlington Hall Station, Arlington (Mailing address: Walter Reed Army Medical Center Washington, DC 20307-5000)

Cameron Station, Alexandria (Mailing address: Walter Reed Army Medical Center Washington, DC 20307-5000)

Davison US Army Airfield, Accotink (Mailing address: Dewitt Army Hospital, Fort Belvoir, VA 22060-5166)

Fort A.P. Hill, Bowling Green (Mailing address: Dewitt Army Hospital, Fort Belvoir, VA 22060-5166)

Kenner Army Clinic, Fort Lee, VA 23801-5260

Vint Hill Farms Station, Warrenton (Scheduled to close 9/1/98) (Mailing address: Dewitt Army Hospital, Fort Belvoir, VA 22060-5166)

Fort Monroe, Hampton (Mailing address: McDonald Army Hospital, Fort Eustis, VA 23604-5567)

Fort Story, Virginia Beach (Mailing address: McDonald Army Hospital, Fort Eustis, VA 23604-5567)

US Coast Guard Supp't Ctr. Clinic, Churchland, Portsmouth, VA 23703

US Coast Guard Reserve Training Center Clinic, Yorktown, VA 23690

Navy Medical Clinic, Quantico, VA 22134-6050

Navy Medical Clinic, Norfolk, VA 23508

Navy Branch Clinic, Arlington Annex, Arlington, VA 20370

NAVSWC Dahlgren, VA 22448-5000

CGMCDEC Mann Hall, Quantico, VA 22134 (Navy)

OCS Camp Uphur, Quantico, VA 22134 (Navy/Marine)

Brown Field, Quantico, VA 22134 (Navy/Marine)

TBS Quantico, VA 22134 (Navy/Marine)

Sewells Point Clinic, NAVSTA, Norfolk, VA 23511

ARF Dispensary, NAS Norfolk, VA 23511

Naval Shipyard, Norfolk, VA 23511

NAVPHIBASE Little Creek, VA 23521

NSC Warehouse Dispensary Norfolk, VA 23512

Dam Neck Base, Virginia Beach, VA 23461-5200 (Navy)

NAVSHIPYD Portsmouth, VA 23709

WPNSTA Yorktown, VA 23691-5021 (Navy)

NAS Oceana, VA 23246

Lafayette River, Norfolk, VA 23508-1299 (Navy)

De-Gaussing Facility, Lambert's Point, Norfolk, VA 23511 (Navy)

NSC Dam Neck, Norfolk, VA 23512 (Navy)

NALF Fentress, Chesapeake, VA 23460-5120 (Navy)

NAVRADSTA, Northwest Chesapeake, VA 23322

HSA CINCLANTFLT, Norfolk, VA 23511 (Navy)

WASHINGTON

Hospitals:

Madigan Army Medical Center, Tacoma, WA 98431-5021

Naval Hospital, Oak Harbor, WA 98278-8800

Naval Hospital, Bremerton, WA 98312-1898

Uniformed Services Medical Treatment Facility, 1131 14th Ave. South, Seattle, WA 98114

Medical Clinics:

US Army Health Clinic, Yakima Firing Center, Yakima, WA 98901

92 Medical Group, Fairchild AFB, WA 99011-8704

62 Medical Group, McChord AFB, WA 98438-1130

US Coast Guard Air Station Clinic, Port Angeles, WA 98362

US Coast Guard, 1519 Alaskan Way South, Seattle, WA 98134

Naval Medical Clinic, NAVSTA, Seattle, WA 98115-5004

NAVSHIPYD Bremerton, WA 98314

NAVSTA Everett, WA 98207-1300

NAVSUBASE Bangor, WA 98315-5720

NAVUSEAWARENGSTA Keyport, WA 98345

NUSWNGSTA Indian Head Det Hadlock, WA 98339

WEST VIRGINIA

Medical Clinics:

Naval Branch Medical Clinic NAVRADSTA, Sugar Grove, WV 26815

WYOMING

Hospital:

90 Medical Group, F.E. Warren AFB, WY 82005-3913

PUERTO RICO

Hospital:

US Naval Hospital, Roosevelt Roads, FPO AA 34051-8100

Medical Clinics:

US Army Health Clinic, Fort Buchanan, San Juan, PR 00934

US Coast Guard Air Station Clinic, Aquadilla, PR 00604

US NAVSECGRUACT, Sabana Seca, FPO AA 34053

Viegues, FPO AA 34053

MEDICAL FACILITIES OVERSEAS

ANTIGUA

Naval Branch Medical Clinic, USNAF Antigua, FPO AA 34054

AZORES

65 Medical Group (Lajes), APO AE 09720-5300

BAHRAIN

Naval Branch Medical Clinic, Administrative Support Unit Bahrain, FPO AE 09834

BELGIUM

SHAPE Health Care Facility, APO AE 09705

CANADA

Naval Branch Medical Clinic, Argentia, Canada, FPO AE 09597-1051

CUBA

Hospital:

US Naval Hospital, Guantanamo Bay, FPO AE 09593-0136

Medical Clinics:

USNAVSTA Guantanamo Bay, FPO AE 09593

Leeward USNAS, Guantanamo Bay, FPO AE 09593

FEDERAL REPUBLIC OF GERMANY

Hospitals:

US Army Hospital—Heidelberg, APO AE 09102

US Army Hospital—Wurzberg, APO AE 09244

Landstuhl Regional Medical Center (Kaiserslautern) APO AE 09180

52 Medical Group (Bitberg/Spangdalem), APO AE 09126-3690

Medical Clinics:

US Army Health Clinics:

Augsburg, APO AE 09178

Babenhausen, APO AE 09089

Bad Aibling, APO AE 09098

Bad Kreuznach, APO AE 09252

Bamberg, APO AE 09139

Baumholder, APO AE 09034

Buedingen, APO AE 09076

Butzbach, APO AE 09045

Darmstadt, APO AE 09175

Dexheim, APO AE 09111

Fiedberg, APO AE 09074

Giebelstadt, APO AE 09182

Grafenwoehr, APO AE 09114

Hanau, APO AE 09165

Hohenfels, APO AE 09173

Ilesheim, APO AE 09264

Katterbach, APO AE 09250

Kitzingen, APO AE 09031

Mannheim, APO AE 09166

Sandhofen, APO AE 09028

Schweinfurt, APO AE 09033

Stuttgart, APO AE 09154

Wiesbaden, APO AE 09096

USAF Clinics:

470 Medical Flight (Geilenkirchen), APO AE 09104-8030

86 Medical Group (Ramstein), APO AE 09094-3215

469 Medical Flight (Rhein-Main), APO AE 09050-8490

US Navy Medical Clinics:

Detachment Landstuhl, Landstuhl Army Medical Center, 2nd General Hospital, APO AE 09180

Detachment Pirmasens, US Army Medical Material Center Europe, APO AE 09138-3584

Detachment Wiesbaden, USAF Lindsey Air Station, USAF Regional Medical Center, APO AE 09220-5300

GREECE

Medical Clinic:

Naval Branch Medical Clinic, USNAVSUPPFAC Souda Bay, Crete, FPO AE 09847

GUAM

Hospital:

US Naval Hospital Guam, FPO AP 96630-1600

Medical Clinics:

USNAS Guam, FPO AP 96630

USNAVMAG Guam, FPO AP 96630

USNAVSTA Guam, FPO AP 96630

NAVCAMS West Pac, Guam, FPO AP 96630

Occupational Health, USNAVSTA Guam, FPO AP 96630

36 Medical Group, Anderson AFB Guam, APO AP 96543-4010

ICELAND

US Naval Hospital Keflavik, FPO AE 09728-0308

ITALY

Hospitals:

US Naval Hospital Naples, P.O. Box 19, FPO AE 09619-0070

US Naval Branch Hospital, USNAF Sigonella, Sicily, FPO AE 09627-2500

Medical Clinics:

US Army Health Clinic, Camp Darby, Livorno, APO AE 09613

US Army Health Clinic, Livorno, APO AE 09613

US Army Health Clinic, Vicenza, APO AE 09630

31 Medical Group, Aviano AFB, Italy APO AE 09601-0245

USNAVSUPPACT Det, Gaeta (Mailing address: Commander, Naval Medical Command, European Region, P.O. Box 22, FPO AE 09499)

USNAVSUPPO LaMaddelena, Sardinia (Mailing address: Commander, Naval Medical Command, European Region, P.O. Box 22, FPO AE 09499)

JAPAN

Hospitals:

35 Medical Group (Misawa), APO AP 96319-5024

374 Medical Group (Yokota), APO AP 96328-5000

Naval Hospital, Okinawa, FPO AP 96362-1600

Naval Hospital, Yokosuka, FPO AP 96350-1615

Medical Clinics:

US Army Health Clinic, Camp Zama, Sagamihara
(Mailing address: US Army Medical Dept. Activity, Japan
APO AP 96339-0076)

US Naval Branch Medical Clinic Atsugi, U.S. Naval Facility
Box 2, FPO AP 96306-1600

COMFLEACT Sasebo, FPO AP 96322

Kamiseya, FPO AP 98768

18 Medical Group (Kadena) APO AP 96368-5268

Naval Branch Medical Clinic, Iwakuni, PSC 961, Box 1877,
FPO AP 96310-1877

KOREA

Hospitals:

US Army Hospital, Seoul, APO AP 96301-0080

8 Medical Group (Kunsan), APO AP 96264-5300

51 Medical Group (Osan), APO AP 96278-5300

Medical Clinics:

US Army Health Clinic, Pusan, APO AP 96259-0257

US Army Health Clinic, Wongiu, APO AP 96397

US Army Health Clinic, Yongsan, APO AP 96301

US Army Health Clinic, Taegu, APO AP 96218

51st Medical Group—OLB (Suwon AB), APO AP 96461

51st Medical Group—OLB (Taegu AB), APO AP 96213

PANAMA

Hospital:

Gorgas Army Community Hospital, APO AA 34004

Medical Clinics:

Coco Solo (Mailing address: US Army Medical Dept. Activity Panama, APO AA 34004)

Fort Clayton (Mailing address: US Army Medical Dept. Activity Panama, APO AA 34004)

Fort Kobbe (Mailing address: US Army Medical Dept. Activity Panama, APO AA 34004)

Fort Davis (Mailing address: US Army Medical Dept. Activity Panama, APO AA 34004)

Fort Sherman (Mailing address: US Army Medical Dept. Activity Panama, APO AA 34004)

24 Medical Group (Howard), APO AA 34001-5300

SAUDI ARABIA

US Army Health Clinic, Dha Hran, APO AE 09808

SPAIN

US Naval Hospital, Rota, FPO AE 09645-2500

TURKEY

Hospital:

39 Medical Group (Incirlik), APO AE 09824-5000

UNITED KINGDOM

Hospital:

48 Medical Group (Lakenheath), APO AE 09464-0230

Medical Clinics:

423 Med Flight (Upwood), APO AE 09470

USNAVFAC Brawdy, APO AE 09420

US Naval Medical Clinic, London, FPO AE 09499

603 CS/Medical Aid Station (RAF Croughton, UK), APO AE 09494

US Naval Branch Medical Clinic, Edzell FPO AE 09419-0029

US Naval Branch Clinic, St. Mawgan, FPO AE 09409-1006

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